

our family is hurting



"West Virginians are truly one large family. When one member of this family is hurting, we all step forward to provide comfort, assistance and a helping hand."

West Virginia Governor Joe Manchin



our family is hurting

West Virginians are a family and one part of our family is hurting those with mental illness and their relatives. Our citizens used to have a community system of services that was there for them. These supports are evaporating.

The numbers tell the tale of despair:

- **The suicide rate for young adults in West Virginia grew 85% between 1999-2001 and 2002-2004.¹**
- **The number of mental hygiene petitions for involuntary commitments filed in West Virginia in 2006 was 8,877, a 60% increase from 2000.²**
- **The number of commitments to state hospitals grew 219% from 2001 to 2005.³**
- **Mildred Mitchell-Bateman hospital was cited for overcrowding and is now forced to add many new beds.⁴**
- **The number of homeless with mental illness grew over 300% from 2001 until 2004.⁵**
- **West Virginia drug overdose rates have risen 550 percent between 1999 and 2004.⁶**
- **More than 1 million emergency room visits annually are related in whole or in part to mental health and substance abuse cases.⁷**

- **The National Alliance on Mental Illness issued a 2006 “Grading the States” report card. In their initial look at how health care systems are doing when it comes to helping those who are seriously mentally ill, West Virginia received a “D.” The state’s services to the seriously mentally ill earned a “D+,” while recovery support programs were given a “D-”.⁸**

These numbers do not tell the human suffering caused by the erosion of the community behavioral health support for those with mental illness. Throughout this paper, we will highlight personal stories. These problems have been discussed for years; action is needed now.

For more information, please contact the West Virginia Behavioral Health Care Provider Association at 304-343-0728.

Tracy

“Tracy” is a single mother and Medicaid recipient in the Morgantown area who has benefited from targeted case management services. She and her 14-year-old daughter, Vanessa, have no income other than a \$30 a month in child support. They live in an isolated area in a rundown, HUD-approved home that used to be a garage. They have no telephone, no form of transportation and no cable service. Tracy has poor physical health, a severe mental illness, and no identifiable skills that would allow her to obtain gainful employment. Tracy and Vanessa typically run out of food by the middle of each month.

Vanessa has needed intensive individual therapy because of a sexual assault. She has attempted suicide three times. Because she was poor, Vanessa suffered badly from bullying at school. Tracy’s caseworker arranged to get her admitted into a Catholic school, where bullying is not tolerated, with a full tuition waiver.

“Tracy was one client who was treatment-motivated and actively participated in her

treatment,” her caseworker says. “This is a mother who wanted very badly to provide for her daughter and make life for the both of them a little easier. We reached a point where we managed to build an unshakable trust as we began to implement a planned treatment course with focus on goals and objectives.”

Tracy needs the structure and support offered by targeted case management, which includes supportive individual counseling, advocacy with her physician for effective medications to reduce symptoms and promote healthy functioning, assessment of any unexpected new problems, referral to other outpatient and inpatient services, service planning, crisis response planning and service plan evaluation to ensure that her treatment needs are being met.

Unfortunately for Tracy, she was placed, without her knowledge, into just basic coverage in the Medicaid program, making her no longer eligible for targeted case management services. Nor is she eligible for crisis residential services in the event that her condition is elevated to crisis level. Tracy and her caseworker tried hard, but unsuccessfully, to change Tracy’s status so that case management for her and Vanessa would become available again.

Tracy cried when she learned that her caseworker could no longer provide her with targeted case management. “I can’t lose you,” she said. “I have no one else who cares about me, who has helped me as much as you have.” Since then, Tracy’s condition worsened to severe clinical depression. Not only has her mental health declined, but so has her physical health and socioeconomic status. Her caseworker fears that Tracy and Vanessa might act upon their thoughts of suicide.



Community Support System for Behavioral Health Must Be Rebuilt – People Need Help

Deinstitutionalization and re-institutionalization

Many of West Virginia's most vulnerable and underprivileged citizens are having problems getting the range of services and depth of services they need, because behavioral health care providers are not receiving the support and cooperation they need from state government. The tough task the providers have in serving those people is challenging in even the best of circumstances. The regulation, oversight and coordination of behavioral health policy by state government is also challenging, especially over many years, as people move in and out of key positions. Unfortunately for the providers, the actions of state government often have been inconsistent with—and sometimes contradictory to—the goals of maintaining an effective and efficient behavioral health system.

About 20 years ago, West Virginia had become a national leader in the process of “deinstitutionalizing” behavioral health care patients. The state could claim a 95 percent success rate in moving patients out of costly institutional care and into community-based treatment. That process included the closing of nine state psychiatric hospitals and reducing the number of institutionalized psychiatric patients from a one-time high of 5,410 to 224 by 1994.⁹

After such notable progress, the decline of the past 15 years is all the more remarkable. In that time, providers have received no meaningful increases in reimbursement rates and repeated reductions in rates for some services. Medicaid reimbursement to behavioral health care providers dropped 28 percent, or more than \$34 million, from 1997 to 1999¹⁰ and another 36 percent, or \$41 million, with the institution of managed care in 2000.¹¹ Hardest hit were clinic-based services, rehabilitation services and case management services—the main sources of funding for non-profit behavioral health care centers.

The state cut another \$27 million of behavioral health care funding in 2002¹². Then in 2005, the Legislature chose to cut \$115 million in Medicaid spending to cope with a budget shortfall, even though only one quarter of that was state money and the federal government paid the rest.¹³ In addition, the state does not allow behavioral health care providers to receive the same annual inflationary rate adjustment that hospitals, pharmacies and other providers receive, even though the behavioral health care providers must cope with the same inflationary pressures that affect the other providers. From 1993 to 2008, the rate of inflation was more than 50 percent.¹⁴ Because of these reductions in funding, behavioral health care providers are no longer offering certain services. In addition, some services that were available in traditional Medicaid under the Clinic and Rehabilitation categories are no longer available under Specialty Services in the redesigned Medicaid program. Because of these reductions in funding, behavioral health care providers are no longer offering such services as clinic rehabilitation. The number of providers with a full range of services has declined. The mental health system is in disarray, and many people who need its services are instead ending up in jails or in hospital emergency rooms or homeless on the streets.

The lack of adequate funding contributed to the bankruptcy of at least five providers and the closing of many treatment programs. This is a case of the state acting blindly against its own best interest, because many patients who had been living successfully in their own communities have been reverting back to institutional state care, crowding back into state hospitals at a cost of about \$200,000 a year.¹⁵

This is one reason why the state ombudsman for behavioral health uncovered deplorable conditions, including overcrowding, at Mildred Mitchell-Bateman Hospital, one of the two state psychiatric hospitals, in June 2008. After employees picketed the hospital in October, Mary Beth Carlisle, the hospital's chief executive officer, said that, in addition to needing more fulltime positions and better pay, "We need to build up our community mental health programs to care for the people."¹⁶

Dr. Shahid Masood, Bateman's clinical director, also blamed the hospital's overcrowding on the slashing of programs at community-based mental health centers in response to funding cuts. That included the closing of group homes that housed people with mental illnesses and the elimination of day treatment centers. When mentally ill people have nowhere else to turn, Masood said, they "decompensate" and become dangers to themselves and others. "They're decompensating because of a lack of services in the community," he said. "There's no other option left but to come here."¹⁷

The lack of community-based mental health services also is apparently a contributing factor to what Dr. Rolly Sullivan, medical director of addiction services at West Virginia University, calls "a rising epidemic" of West Virginians' abuse of prescription painkillers and a 550 percent increase in accidental drug-overdose deaths over five years.¹⁸

To solve these problems, the state needs to take a number of steps to restore community-based behavioral health services.

The creation of a state system of regular rate review and rate-setting processes

Community infrastructure, which includes group homes, day treatment services, and support services, has eroded over the years. This has placed greater burdens on the state to find appropriate community-based programs for placement of people who are stable and ready for discharge from state hospitals. In addition, wages have not kept pace with the ever-increasing cost of doing business, which makes it difficult to attract professional and direct care workers to community-based programs.

Other factors also contribute to the difficulty and increased costs of maintaining an adequate workforce. They include federally mandated increases in the minimum wage, the increasing cost of workers' compensation premiums, the cost of such workers' health benefits as medical care and life insurance, and the overall cost of inflation. For example, the minimum wage in 1992 was \$4.25 per hour. Since July 24, 2008, the federally mandated minimum wage has been \$6.55. On July 24, 2009, it will be raised again to \$7.25.¹⁹

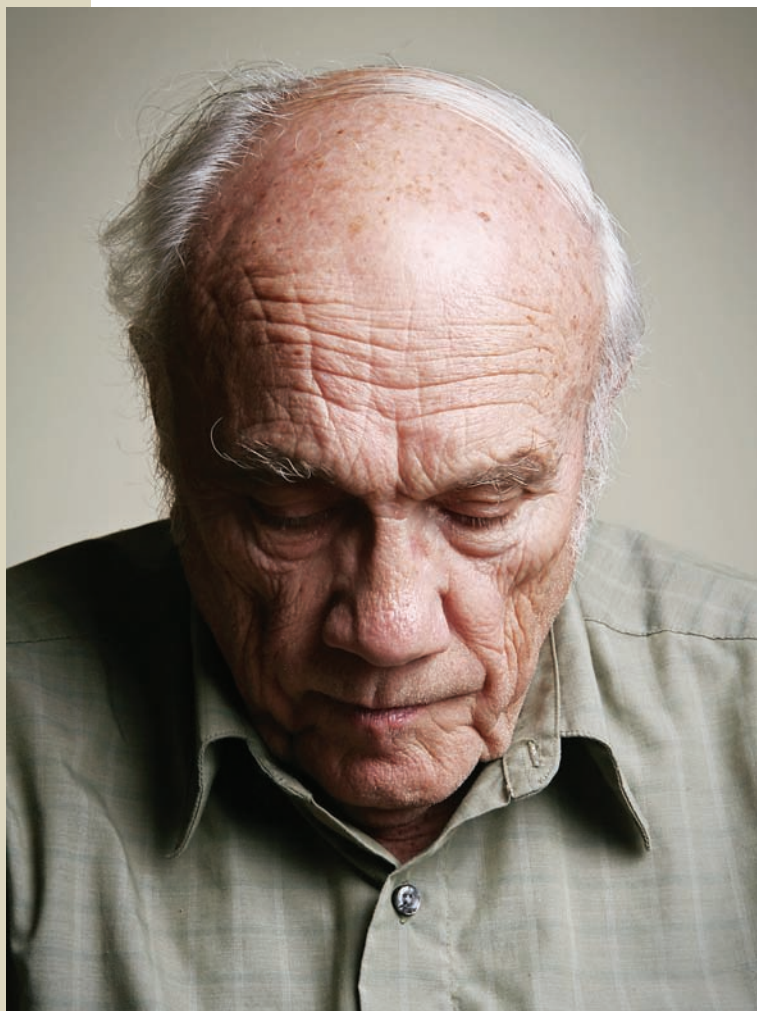
Generally, West Virginia's reimbursement for behavioral health care under the Medicaid program and under state-funded behavioral health care programs for indigent patients has not increased since 1992. The primary exception was a 2006 increase in some waiver rates under a financial formula created by the Bureau for Medical Services staff.

It would be prudent for West Virginia to use an annual rate review and rate-setting process for community-based behavioral health care programs similar to the process already used for general hospitals and nursing facilities. That process would ensure that high-quality, community-based programs remain in place with a qualified workforce.

John

“John” has a long history of such psychiatric problems as bi-polar disorder, obsessive-compulsive disorder and depression, as well as alcoholism. He moved to the Weirton area about five years ago to live with his mother. After her death three years ago, John began to drink heavily and had to be hospitalized several times because of suicide attempts. His house had become rundown. His utilities were cut off because of non-payment.

A case management program helped John re-establish his SSI benefits, apply for food stamps, get his utilities restored and get groceries from charities. He stopped drinking. His symptoms of depression and bi-polar disorder have lessened, although they are still present. He sees a substance abuse counselor faithfully and takes steps to help himself whenever possible. But this success in helping John live with an acceptable quality of life in his home community would be at risk if community mental health services were not available to him.



Residential supports

The withdrawal of federal permission in the late 1990s for West Virginia to continue to use a Medicaid service known as “Basic Living Skills Supports” forced many residential and group home facilities to close, eliminating community placements for many behavioral health care patients.²⁰ That support service allowed staff to work three shifts in supervised residential settings in communities. Unfortunately, federal officials at the time considered it as a “habilitative” service that maintained individuals in the community rather than a “rehabilitative” service that would have restored individuals to former levels of functioning. According to federal officials, the Medicaid Rehab Option does not permit payment for habilitative services.

The lost community residential infrastructure could gradually be restored by dedicating state-only funding instead of Medicaid funding to one residential project per region to support high-need individuals in residential or apartment settings with staff support 16 to 24 hours per day, according to need.

Mobile crisis teams

At one time, the state considered it a priority to dedicate a state funding stream to create mobile crisis teams that could be dispatched on an emergency basis. Those teams would handle psychiatric crises in communities before considering immediate placement of individuals in crisis in state hospital beds or emergency rooms. However, few mobile teams were piloted, probably because of the geography and rural nature of West Virginia. Nevertheless, there is merit for mobile crisis response teams in more urban areas, where time, distance and available staff present fewer barriers. When possible, early intervention could alleviate most costly treatment options, such as hospitalization, which tends to lead to over-bedding.

In more rural areas, where mobile crisis teams are less feasible, a return to grant-based funding for wrap-around services is warranted. Once-available state funding has dwindled over the years or has been targeted to very specific projects, which has resulted in unequal distribution of services. Rural communities have been hurt the most, but this does not need to be the case. The largely Medicaid-based, fee-for-service funding environment makes it possible to provide 24-hour-a-day services.

Creation of regional interdisciplinary teams specializing in the diagnosis and intervention of co-occurring disorders

Many times, people with co-occurring conditions of chemical dependence and mental illness have had to seek treatment for just one condition. Specialists trained to intervene simultaneously to handle both conditions usually can be found only in expensive hospital settings. Pilot funding could be set aside in four regions of the state for the creation of interdisciplinary teams that could provide local intervention for people with both conditions, which could prevent more expensive hospitalization.



Mary

From 1995 through January 2008, “Mary” spent about 1,700 days in treatment at Sharpe Hospital at a cost of about \$1.5 million, because the intensity of treatment she needs on an on-going basis is not available in her community. She also has received treatment at additional cost at other inpatient facilities and a local crisis unit. Although she is fairly bright and articulate, Mary experiences chronic depression and schizoaffective disorder, and she often makes poor choices. Frequently, she becomes suicidal and acts upon impulses to hurt herself. Her family support is minimal. She is isolated socially with no support in the community, so she relies upon clinic personnel to meet her social needs.

Mary could be treated much more effectively at a much lower cost in a structured group home or similar arrangement in which individual attention is available around the clock, but the current Medicaid system provides no way to cover the costs of such intensive service.

Creation of a training center for co-occurring disorders

Each of the two major universities in West Virginia offers professional degree coursework in psychology, and each has a medical school with a component that offers specialty training in psychiatry. Each has a history of working with the Office of Behavioral Health Services (OBHS) on studies and community-based initiatives of mutual interest. Recently, OBHS hired its first clinical director, who works on a part-time basis and is a psychiatrist affiliated primarily with the WVU medical school's psychiatry program. It would be valuable to involve the universities and OBHS in creating a training program for community-based professionals to work in their communities with individuals with co-occurring conditions of addictions and mental illness.

Along with such training, funding should be dedicated for specialized programs and projects within communities to serve individuals with co-occurring disorders.

Development of regional emergency detoxification beds for addicts who require immediate treatment

A number of individuals who require immediate treatment are intoxicated. These individuals often have psychiatric symptoms that resolve themselves when they become sober. Sometimes, these individuals are placed inappropriately in the state hospitals by default. The hospitals' staffs do not believe they are equipped to engage appropriately in medical detoxification, so some addicted individuals fail to receive appropriate and necessary care for their primary problems. This problem could be alleviated by developing a system of regional emergency detoxification beds.

Regional residential group homes for those having diagnoses of MR/DD and behavioral disorders

Both Sharpe and Bateman hospitals are short-term, acute-care psychiatric facilities. However, many of their beds are used by individuals over long periods, sometimes for more than a year.²¹ This is because community placements are not available for people with behavioral disorders combined with diagnoses of MR/DD. Creating small, specialized regional group homes to serve this specific population could help to free up bed space in hospital settings.

Leslie

"Leslie" was age 17 when she was diagnosed with depression following 11 years of sexual abuse. She suffered post-partum depression following the birth of her first child. Her depression worsened after her mother's death in January 2008. Twice, she has attempted suicide. In April 2008, Leslie jumped out of a moving car. She was taken to a local hospital for inpatient psychiatric care but was denied admission because of lack of insurance.

Fortunately, Leslie was admitted to a crisis stabilization unit, where she received care she credits with getting her life back on track. Later, she obtained a Medicaid card but was enrolled in just basic coverage through Mountain Health Choices. In October 2008, her depression worsened so much that she was having auditory hallucinations.

She attempted to return to the crisis stabilization unit, but that service was not included in her basic coverage. Despite her lack of coverage, she was able to get admitted to a crisis residential unit and get her symptoms back under control. Nevertheless, Medicaid failed to provide her with the help she needed.



A return to the original intent for the use of civil commitment beds

As noted above, West Virginia once had more than 5,000 institutional beds, but the state was very successful in moving patients from institutions to community-based services so that only two state psychiatric hospitals with a combined total of 240 beds remain. However, more than half of those beds are occupied by forensic patients, individuals who have been assigned for treatment by the courts. At the same time, the need for civil commitments for determination of mental hygiene has not diminished. That has resulted in the hospitals exceeding their capacity and becoming overcrowded.²²

Consequently, the state constantly must find millions of dollars of new funding to pay for diversions to beds in private psychiatric hospitals. It would be much better for the state to find the means to accommodate the forensic patients outside of the mental health system.

Telemedicine—an underutilized resource

Many behavioral health centers around West Virginia have invested – often with the help of grants – in technology that permits them to engage in telemedicine, videoconferencing and distance learning programs. The telemedicine capabilities in particular could be useful in expanding the reach and effectiveness of the health care professionals at those centers at relatively low cost. Other types of health care services have multiple Medicaid billing codes for telemedicine, but only two such codes do exist for telemedicine in behavioral health care.

Increasing the number of Medicaid billing codes for telemedicine in behavioral health at a reasonable reimbursement rate would help strengthen community-based services and help the state hold down behavioral health costs. Medicaid and the state must also see the value in the use of this technology; it is working in many other areas of the country. This is especially important in West Virginia, the second-most rural state, with a shortage of psychiatrists and psychologists.

Integration with primary care

West Virginia needs its health care providers to take whole-body approaches to treating patients' physical and mental problems. The state must facilitate the integration of primary care with behavioral health care. This would mean having primary care doctors at behavioral health care centers and mental health providers at primary care clinics or cooperative arrangements so that primary care and behavioral health centers support each other.

People with behavioral health problems represent a fragile population. They are dealing with crucial and sensitive life issues. The health care system must have a simplified process for getting them the help they need.

Without an integrated system, many people are unlikely to receive the most appropriate care. Consider someone who goes to a mental health facility because of depression. If no one at that facility checks the patient's cholesterol level, blood pressure and other signs, a key factor in the depression might be missed. Likewise, if the patient would go to a primary care doctor, that physician might give the patient a prescription for medication that could address the person's symptoms. But unless the patient is counseled by a mental health professional, stressors that are causing the depression could be missed.

The system needs reasonable reimbursement processes and a regulatory structure that facilitates treatments of physical causes for behavioral health problems and mental causes for physical health problems.

Conclusion—Rebuild the system

West Virginia must rebuild its system to provide community-based support and treatment for behavioral health problems. Failure to do so will result in the continuation of increased and unnecessary costs in both human and financial terms. People lives will be negatively impacted if nothing is done.

If West Virginia does not provide reasonable and adequate care to troubled individuals within their communities, many of them will show up in jails, prisons, and hospital emergency rooms, as well as on the streets. The state will use more precious health care resources if there is not a rebuilding of the community system.

To rebuild the system in an organized fashion will save money and give people a higher quality of life. But the longer such rebuilding is delayed, the worse the problem will become and the harm that will be done to those with mental illness will be more expensive for the state.

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