PROJECT HOPE

COMMUNITY NEEDS ASSESSMENT

MENTAL HEALTH SERVICES

KEY FINDINGS, NOVEMBER 2016

Community Foundation
of Greater Dubuque

United Way

United Way of
Dubuque Area Tri-States

ACKNOWLEDGEMENTS

CITATION

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INTRODUCTION

Project HOPE, an initiative of the Community Foundation of Greater Dubuque (CFGD), partnered with the United Way of Dubuque Area Tri-States to conduct a needs assessment that took a focused look at needs and barriers to economic opportunity in Dubuque. To select focus areas, 75 professionals were surveyed from a broad cross-section of service providers. Mental health and child care services were overwhelmingly identified as pressing needs.

The diversity of service providers who ranked these needs so highly points to the critical role that both mental health and child care services can play in a family's stability and ability to advance their economic future. Both of these services are needed for personal well-being, and in many cases, lack of access to mental health and child care services inhibits individuals from going to work or achieving other goals.

Project HOPE seeks to increase access to education and employment opportunities for all by creating awareness and exploring solutions to systemic barriers. Our hope is that this needs assessment will serve as a resource to help inform the work of those in the field; influence current programming; aid efforts to obtain funding and resources; and provide data to help engage policy makers. This summary focuses on the mental health findings. To obtain a complete report for both child care and mental health services, email office@dbqfoundation.org.

METHODOLOGY

The needs assessment, which started in December 2015 and concluded in June 2016, engaged the Project HOPE network, as well as research firm Strength in Numbers Consulting Group (SiNCG), and Loras College Social Work Professor Michelle Bechen to assist with data and research efforts.

CFGD, United Way and SiNCG convened a Community Assessment Working Group (CAWG) composed of representatives from each organization and additional interested community members. The working group also engaged advisory members, who were recruited based on their knowledge and experience in mental health, along with their willingness and capacity to guide the needs assessment process on a voluntary basis.

During a kickoff event, 40 social service providers, government stakeholders and business leaders participated in a SWOT analysis (strengths, weaknesses, opportunities and threats). This analysis helped identify themes of interest and then narrowed them to focus on important, actionable research questions. Inputs to the needs assessment included:

- Key Informants: Three interviews were conducted by SiNCG. Informants were identified by the CAWG as knowledgeable service providers who were willing to lend their perspectives early in the research process, helping to identify key themes.

- Mental Health Focus Groups: Three focus groups were conducted in January 2016—one with direct service providers and two with administrative and management-level staff. Twenty-two total providers across multiple specialties participated in the three groups.

- Mental Health Service Inventory: CFGD staff designed and distributed an online survey to known area providers. The survey requested information about payment acceptance, prescribing services, counselors, wait times, inpatient beds and substance abuse services. Twenty-four providers responded to the survey.

KEY FINDINGS

This section describes the findings from the mental health focus groups and the mental health services inventory. While the inventory was not exhaustive, all known providers were contacted, and only one provider did not participate. This inventory does not include counseling services provided by colleges and universities, and many of the providers who participated serve patients beyond the Dubuque city limits.

The focus groups addressed the following research questions:

1. What are the strengths of the Dubuque-area mental health system and service providers?

2. What are the most pressing needs and challenges in mental health in the Dubuque area?

3. Is coordination of resources a problem in the area, and if so, what are the underlying reasons for this problem? What existing coordination mechanisms exist and what, if any, new coordination mechanisms are needed?

4. Is Medicaid modernization creating new challenges?

5. What is the best way to address existing challenges and build on existing strengths?

MEDICAID AND FUNDING CHALLENGES

Overall, focus group participants reported operating in an environment where resources are diminishing, while community need is growing and funding structures are becoming more rigid. One provider summarized new funding challenges by saying, "The need goes up, but the money goes down," (MH1[1]).

Funding in Dubuque is decreasing due to state-wide regionalization strategies that have caused resources to be spread more thinly in order to serve a broader population. This strategy enables more people to have access to services, but often affects the availability of those same services. According to one provider, "In order for everyone [in Iowa who needs services] to have the 'core services', some who were doing well and had extra services can't have those anymore to ensure that everybody gets those core services," (MH1). Another provider mentioned that, "community members in need of domestic violence services may need to travel to Waverly, a two-hour drive, to access services," (MH3).

> **" The person needs to fit the funding and the funding doesn't fit the person. "**

Another provider noted that rigid funding structures don't reflect the reality of complex mental health needs by saying, "The person needs to fit the funding, and the funding doesn't fit the person," (MH1). The funding structures don't fit the reality of someone living with severe mental illness, who may be disorganized and unable to consistently attend appointments, as pointed out by one focus group member who said: "If you don't show up within the first 30 days, your file is closed, and you have to start all over again," (MH2).

Nearly as challenging as rigid funding structures is the increased uncertainty about Medicaid reimbursement rates. Providers expressed anxiety with regard to their ability to provide continuity of care to patients due to the statewide privatization of Medicaid. Of the 19 providers accepting Medicaid, five stated they are already accepting fewer Medicaid patients due to the

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[1] MH1 references a participant from mental health focus group 1. MH2 and MH3 will represent participants from those respective focus groups.

proposed changes. For those continuing to accept Medicaid patients, what remains to unfold in the coming months is how changes in coverage will affect patients' access to specific services and therefore their continuity of care.

The combination of continually changing funding streams, more rigid funding structures, and dramatic changes to Medicaid creates uncertainty among mental health providers and limits service.

Types of Payment Providers Accept

PAYMENT TYPE*	ACCEPTING PROVIDERS
Private Insurance	22/24
Medicaid	19/24
Limited Medicaid Acceptance	19/24
Direct Payment	17/24
Sliding Scale	12/24

*Respondents were allowed to select multiple responses for this section

MEETING SPECIALIZED AND CHANGING NEEDS

Focus group participants discussed concerns surrounding the increase in low-income residents with mental health needs and residents who are at high risk for mental health problems. This increase has elevated the need for specific types of services. For example, one focus group participant recognized that recently there has been, "More poverty, more violence, more exposure to trauma and violence," (MH1). Another spoke specifically to the difficult backgrounds of some young people: "A lot of traumatized youth [who are] in therapy at schools are coming from other areas of Chicago…Dubuque wasn't quite ready to handle [this]; they did not know what to do with kids who had literally watched people die in front of them [and] get shot at and…[who have lived in] extreme poverty," (MH3).

Another participant spoke of the challenges of reaching out to community members who need

services but are reluctant to seek them due to stigma or are un- or under-insured because of challenges related to citizenship: "…how do we involve and engage Marshallese families because they are so insular, and how do we reach out to the community and use members of the community to reach back in to help those people because some of them are extremely ill. And they're not eligible for Medicaid, so they're uninsured, they have no money," (MH2). Service providers reported a strong desire to reach out to underserved communities. Barriers to that outreach include capacity for outreach and treatment of specialized needs, and funding to treat uninsured clients.

While it is unclear whether demographic changes or reduction in resources is having the larger impact, the combination of the two is placing a strain on local providers.

LACK OF OPTIONS FOR DUAL-DIAGNOSIS PATIENTS

Focus group participants reported an increase in patients with dual-diagnosis needs (most often several co-occurring mental health conditions, or a combination of mental health conditions and substance use disorders). "We don't really have anywhere [to refer people to who have a] dual diagnosis…the increase in substance use disorders leads to an increase in mental health [problems],"

(MH2). Providers also cited more cases of serious mental illness: "I feel like [the] chronic mental health [e.g., schizophrenia, borderline, bipolar] thing is more serious than it was three years ago," (MH2).

Providers reported difficulty meeting patients' needs, because many substance use disorder treatment programs cannot accept people with complex mental

health needs, while many mental health providers cannot treat substance use disorders. Seven out of 24 providers in the inventory indicated they offer treatment for substance use disorder cases. Of those seven, two offer this treatment only as co-occurring with other mental health factors and do not have staff dedicated to this service. One of those two serves pediatric patients only. Of the remaining five providers, one offers this service only to veterans, and one only to patients in their pediatric residential program. Three of those organizations reported operating at over 90% capacity in the past year, with only one of these indicating their capacity is expected to increase over the next three years.

The increasing number of patients with a dual diagnosis, along with the limited number of providers and inpatient beds, leaves many patients underserved or not served at all.

19.94

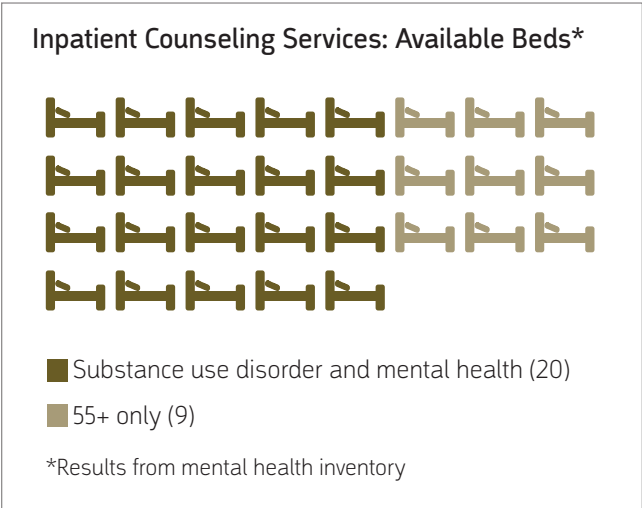Number of full-time substance use disorder counselors reported from five mental health providers.

60%

of substance use disorder providers reported operating at over 90% capacity last year.

LIMITED CAPACITY AND BARRIERS TO CARE

Providers in the focus groups expressed a limited ability to meet the need for mental health services in the community, which is reflected in the capacity reported in the mental health services inventory.

Inpatient care providers reported a frustrating lack of options for inpatient mental health care that, in some cases, resulted in very sick people being released without treatment. For example, during discharge from inpatient care, "We get a lot of calls at the shelter for [people] being discharged that have nowhere else to go," (MH1) or as a result of mental health centers closing, "...it's huge. We don't have anywhere to send anybody. We've had so few beds already, and now it's like we don't have anywhere to put people who really need help," (MH3).

Two out of 24 providers reported offering inpatient counseling services during the inventory; one offers 20 beds and the other offers nine beds that serve only adults 55 years old and older. Over the past year, both have indicated running at 80% or higher capacity. Long-term residential care for youth is available through one provider, with a capacity of 49 beds and 12 temporary "shelter beds" that are available to youth in the Department of Human Services and Juvenile Court Services system. There are 89 long-term residential beds available to adults—18 of which are in a group

Inpatient Counseling Services: Available Beds*

■ Substance use disorder and mental health (20)
■ 55+ only (9)

*Results from mental health inventory

home setting. Adult residential providers reported operating at 100% capacity.

Twenty out of 24 providers interviewed offer outpatient care. Four of those providers serve pediatric patients only, while one serves only veterans and one serves adults 55 years old and older. When looking at capacity, 90% of respondents (18/20 who provide outpatient counseling) reported their outpatient counseling services were operating at or above 70% capacity in the past year, with 11 of those operating at 90% capacity. Some (11/20) expect their ability to see more patients increase over the next three years.

Another topic discussed among providers was the myriad of barriers that prevent patients from receiving care. Providers noted that some patients had problems keeping regular appointments. Missing appointments made it difficult for these patients to access care in the future and lengthened the waitlist for other patients in need of limited services, as echoed by one provider: "If you're not fully invested in your psychiatry appointment, you don't show up, so there's many days that we have nine appointments and two people show up," (MH1).

During the focus groups, child care and transportation were also identified as barriers to accessing mental health services, along with insurance issues. "I think it's always nice for people to have options in regards to primary care, really for any matter, so it would be nice to see more providers accepting Title 19," (MH2), said one respondent. Sixteen survey respondents answered follow-up questions about client wait times. Seven of

Highest Contributors to Wait Times

- lack of available appointments
- no-shows
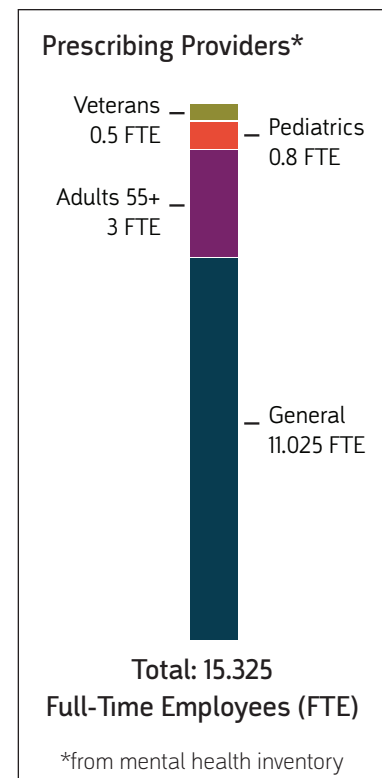- issues with scheduling
- transportation

those believed wait times were a "moderate or above" barrier, citing many of the reasons above as factors that contribute to longer wait times.

Most inpatient and outpatient care providers are operating at or near capacity and patients are facing barriers such as lack of transportation or child care—leaving them with less flexibility, longer wait times, or nowhere to go to get the care they need.

LACK OF PRESCRIBING PROVIDERS

In addition to a rise in complex mental health needs and a lack of options for inpatient care, focus group participants reported a shortage of providers who could prescribe psychiatric medications. According to one respondent, "Some people are going without meds for quite a long period of time just because of their mental illness or being irresponsible," (MH3). Another respondent said, "It is hard to find prescribers and then once you get a prescriber for that medication, they relocate," (MH2). Community-based mental health treatment programs reported difficulty recruiting and retaining trained providers. Providers also reported challenges managing medications effectively and coordinating care for complex mental health conditions. As of July 2015, Dubuque County is a designated Health Professional Shortage Area for mental health according to the Health Resources and Services Administration. However, providers did not feel that this designation has translated into increased resources to attract and retain mental health professionals.

Seven out of 24 respondents to the mental health inventory reported offering prescribing services. Of those seven, two served pediatrics only, one strictly served veterans, one was dedicated to adults 55 years of age and older, and one utilized prescriber services contracted through another agency. Over half indicated that they have operated at 90% capacity or higher over the past year, and only three expected their capacity to increase in the next three years.

Prescribing Providers*

Veterans 0.5 FTE
Pediatrics 0.8 FTE
Adults 55+ 3 FTE
General 11.025 FTE

Total: 15.325
Full-Time Employees (FTE)

*from mental health inventory

COMMITTED PROVIDERS SEEK GREATER COORDINATION

While growing needs and shrinking resources have created many challenges for Dubuque area mental health professionals, they are also responding to these changes by nurturing their own community to ensure the best possible services can be provided at the local level. They draw upon unique assets including the dedication of a supportive and well-connected community of providers; mission-driven workers; and the cooperation of multiple agencies in a robust referral network.

Focus group participants described the supportive and well-connected community of providers in these ways: "Passionate people surround you at your work, whether it's the people you are working directly with or the people in your organizations who are working diligently," (MH1) and "All of us are willing to do all that we can, within our limits, to help… that's why we're here today," (MH1). Another said: "We have our staff do their own mission statement, safety plan and stress plan. Whether it's for anxiety or stress or fear or whatever it might be, you can talk about it," (MH1).

> ❝ My dream is to have a health and human services campus in the Washington neighborhood, so that lots of people who live down there have easy access to whatever they need under the same roof. ❞

In addition to describing how they manage their own stress while remaining committed to their jobs, providers described a robust referral network, often naming the employees from other agencies or organizations that they would reach out to when they have a client in need of services. "…we try to contact that provider or that service or whoever we refer the client to and I think it's more of a courtesy to who we are referring to, like I don't want to just dump people on you or have people calling and you have no idea of their background or what they're asking for or what their needs might be," (MH3).

More than 30 different social service agencies, medical providers and nonprofit organizations were mentioned by name during the focus groups. Providers stated they referred clients for the following types

of services: mental health counseling, food or fuel assistance, case management, employment services, social support, medical services, children's services, domestic violence and/or sexual assault services, access to public benefits, substance use disorder treatment, and disability services, among others. Many service providers also reported participating in advisory groups, such as the Homeless Advisory Council Coalition, where they connect with other service providers and discuss pressing issues in their community.

Despite, or perhaps because of, the robust referral network, one of the top goals that emerged from focus group participants was to further strengthen coordination by providing a "one-stop-shop" for mental health services. Providers stated, "My dream is to have a health and human services campus in the Washington neighborhood, so that lots of people who live down there have easy access to whatever they need under the same roof," (MH2) and "It would be nice to have us all … in the same area where it's like, and so how do I say this, a one-stop shop," (MH3).

Providers also discussed how existing structures and systems could better meet patient needs. For example, coordination of crisis care between the mobile crisis unit[2], community-based mental health care options, and the hospital emergency room were identified as areas that could be enhanced (e.g., MH3).

Providers value the close network of providers and the supportive community, but see opportunities to improve coordination to enhance services.

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2   During the mental health inventory, Hillcrest Mobile Crisis Services reported availability for crisis stabilization services with a capacity of two beds, along with a mobile clinic. Capacity has substantially increased over the past three years, and is expected to continue to increase over the next three years. This service is available to anyone 18 years and older experiencing a mental health crisis and is mostly mobile outreach, reducing the need for inpatient beds.

Challenges in coordinating timely care amidst a shrinking resource pool can have detrimental effects on patients with serious mental illness. The following story highlights the experience of a patient utilizing mental health services in our community.

Brynn's Story

After a series of traumatic life events, Brynn was diagnosed with major depression in 2013. Throughout her college career in Michigan, she was able to manage her depression with the help of good insurance, a campus healthcare system, support from her friends and the structure that school provided. Upon graduation, Brynn moved out of Michigan for the first time in her life to Dubuque in June 2015, where she had accepted a position as an AmeriCorps VISTA. After signing up for Medicaid, Brynn made an appointment to see a general practitioner, where she waited three months before she could be seen to obtain a referral to a psychiatrist. It wasn't until January 2016 when Brynn was able to see a psychiatrist.

Throughout that eight-month period, Brynn was able to rely on medication left over from her previous physician to help, along with talk therapy, but still struggled to get by without the structured therapy provided by a psychiatrist.

> " I was doing everything right, I was asking for help, demanding help and I still wasn't getting what I needed. "

"I was extremely depressed, to the point where I wasn't able to get out of bed. I was functioning, but just enough to get by," Brynn continued. "In September, I ended up in the emergency room because I became so depressed that I wasn't responding—to the point where my doctor was concerned about my safety."

In January 2016, Brynn was finally able to see a psychiatrist. Through therapy and changes in medication, she was able to slowly start climbing out of the darkness she had been living in for months. While Brynn's workplace was supportive throughout her experience, Brynn knows that the stigmas around mental health and socioeconomic status are real, and ones that she has experienced personally.

"Even if there are services available to low-income individuals, there's still this culture where you are treated differently because one, you're poor, and two, you have a mental illness. I'm not sure if it's implicit bias, but it's very different. People just don't understand, and that's reasonable because you really have to feel how terrible someone with a mental illness feels to really get it," said Brynn. "I was doing everything right. I was asking for help, demanding help and I still wasn't getting what I needed. My hope is that some day, severe mental illness is treated with the same seriousness as Leukemia or another major disease."

CONCLUSIONS AND RECOMMENDATIONS

The key findings show that challenges such as limited and changing funding streams, limited capacity of providers, and state-wide regionalization of services has affected the ability to provide services. The recommendations that follow are intended to offer ideas to local stakeholders to address some of the challenges found in the key findings. Recommendations were provided by the Strength in Numbers Consulting Group, with additional insight from review with nine local providers.

▶ **Strengthen Collaboration Among Stakeholders**

Increase collaboration among providers and stakeholders by developing a shared mental health agenda. Actions to consider:

- Convene mental health providers and stakeholders to explore ways to improve coordination.
- Explore partnerships that could support solutions to challenges faced by patients, providers and stakeholders.
- Share data and other information to improve understanding and awareness of mental health needs in the community.
- Increase resources for professional development for providers and stakeholders.

▶ **Develop Solutions to Address Dual Diagnosis**

Create a task force to identify community solutions for dual diagnosis. Actions to consider:

- Ensure providers are aware of existing resources, and proactively develop mechanisms for coordinating care.
- Explore the possibility of establishing a detox center to support patients with a substance use disorder diagnosis.
- Advocate for new resources, such as funding, for existing counselors to obtain training for substance use disorder certification. For gaps identified, the Community Foundation and United Way could also consider inviting proposals for funding to address them.

▶ **Alleviate Barriers that Prevent Access to Care**

Engage existing networks—Changing Minds, NAMI, and Mental Health America— to develop a coordinated effort to build capacity and alleviate barriers. Actions to consider:

- Collaborate with stakeholders to explore barriers to care among underserved populations.
- Support existing initiatives that promote inclusion and cross-cultural exchange in the community and/or develop new ones.
- Incorporate new mental health outreach efforts into existing projects to reach communities that are disconnected from services.
- Build strategic partnerships with social service providers and community groups to form more trusting relationships with mental health providers and explore alternative locations for counseling, including primary care locations.
- Convene a group of stakeholders to research expanding awareness and preventative education efforts in schools and the broader community, including awareness of Hillcrest Mobile Crisis Services.

► Expand Mental Health Prescription Services

Establish a working group to explore options for increasing mental health prescription services. Actions to consider:

- Identify and engage stakeholders knowledgeable about recruiting health professionals and work together to identify programs, resources and opportunities to attract new providers to Dubuque.
- Research and implement best practices in creating awareness around leveraging the practitioner tax credit to recruit additional prescribers who can work with low-income, un-insured, and/or under-insured people.
- Explore options that leverage technology or other innovations to bring mental health prescription services to the community.

► Expand Mental Health Advocacy Efforts

Convene a group to map existing advocacy efforts and incorporate the needs and concerns of local providers into local and state policy advocacy. Actions to consider:

- Identify stakeholders already engaged in advocacy with the goal of increasing coordination and support for advocacy efforts.
- Work to increase opportunities for input into advocacy agendas, and work to establish new ones.
- Provide training to local mental health providers, consumers and concerned residents on how to expand and maximize local advocacy efforts, working with our local elected officials.
- Identify potential regional and state-level relationships with entities that have existing advocacy efforts to share the Needs Assessment findings in an effort to receive support for local advocacy efforts. These organizations could include the United Way of Iowa, Iowa Council of Foundations, the Mental Health/Disability Services of the East Central Region Board of Directors, and the Iowa DHS Children's Mental Health and Well-being Working Group.

NEXT STEPS

The challenges identified in key findings and the recommendations to address these challenges offer a possible road map for next steps. Providers can use findings and recommendations to support or prioritize their own goals or advocate for new ones; administrative leaders can find causes to champion; and funders can identify projects or activities they would like to support. These actions by Dubuque's mental health stakeholders could lead to new grantmaking activities, new programming, and/or new collaborations—resulting in improved conditions for both service providers and mental health service recipients alike.