KANSAS
HEALTH
INSTITUTE

KHI.ORG
Informing Policy. Improving Health.

UNDERSTANDING THE MENTAL HEALTH SYSTEM IN KANSAS

KHI/17-24
OCTOBER 2017

Copyright© Kansas Health Institute 2017. Materials may be reprinted with written permission
Reference publication number KHI/17-24 or view online at khi.org/policy/article/17-24.

212 SW 8th Avenue | Suite 300
Topeka, Kansas | 66603-3936

785.233.5443

khi.org

/KHIorg

@KHIorg

UNDERSTANDING THE MENTAL HEALTH SYSTEM IN KANSAS

OCTOBER 2017

Authors

Jonathan Hamdorf, M.B.A.

Kari M. Bruffett

Acknowledgements

Thank you to officials from the Kansas Department for Aging and Disability Services and the federal Substance Abuse and Mental Health Services Administration for data and feedback. Jon Hamdorf completed work on this project while an analyst with the Kansas Health Institute, and is now an employee of the Kansas Department of Health and Environment.

TABLE OF CONTENTS

Executive Summary iii
Mental Health in Kansas 1
Kansans with Mental Health Conditions 5
Mental Health Facilities in Kansas 8
Mental Health System Workflow 13
Alternative Gateways into the Mental Health System 14
Barriers to Mental Health Access 16
Waiting Lists 16
Transportation Barriers 17
Insurance/Financial Barriers 18
Housing Barriers 18
Cultural, Language and Attribution Barriers 19
Strategies to Address Gaps in the Kansas Mental Health System 19
Gap: Access to Crisis Care 19
Gap: Insurance Coverage 20
Gap: Integrating Behavioral Health and Primary Medical Care Services 21
Gap: Access to Mental Health Services 21
Summary 22
Appendix A: Endnotes A-1

Executive Summary

Mental health systems serve people with mental health conditions. These systems support a wide variety of specialized services delivered by specific providers in a range of care settings. For mental health systems to operate effectively, they need adequate capacity, and patients need to be able to access the appropriate service(s) for their condition(s). When there are capacity issues or patient barriers to services, the resulting gaps can negatively affect patient, societal and system-level outcomes.

Mental health includes emotional, psychological and social well-being. Mental health problems can affect thinking, mood and behavior. Biological factors, life experience and family history can contribute to mental health problems.

While there is movement in Kansas and nationally toward more integrated behavioral health care—more seamless care for mental health problems, substance use disorders and addictions, and primary medical care—this report is focused primarily on the mental health system.

Prior to 1990, state funding for the mental health system was directed to services offered in inpatient settings. Since the passage of the Kansas Mental Health Reform Act in 1990, the structure and funding of the mental health system has begun to shift from inpatient services delivered through state psychiatric hospitals to outpatient services delivered through community providers. This shift has resulted in the expansion of community mental health services, the elimination of two state psychiatric hospitals, and a reduction in mental health inpatient capacity. Closing two psychiatric hospitals reduced the number of available state hospital beds from more than 1,000 beds in 1990 to 250 beds as of late 2016. By 2014, there were 131,963 Kansans receiving mental health services in the community, while 3,994 received mental health services through state institutions, per the Substance Abuse and Mental Health Services Administration (SAMHSA).

To assess how well the mental health system in Kansas serves the population, policymakers can consider the need for mental health services as well as the capacity of the current system. One measure of need for mental health services is the number of people with a diagnosed mental health condition. Conditions with reported data include serious mental illness (SMI), any mental illness (AMI), having suicidal thoughts, and having a major depressive episode in the past year. This report includes data from SAMHSA's National Survey on Drug Use and Health (NSDUH)

comparing the prevalence of these conditions in Kansas to prevalence in its neighboring states and national averages.

The supply of available mental health resources can be measured by the number of mental health facilities and beds, the size of waiting lists for services, and supply of mental health providers. As of February 2017, there were 13 consumer-run organizations, 26 community mental health centers, three community crisis centers, two state-run and four private inpatient psychiatric hospitals, nine psychiatric residential treatment facilities, 10 nursing facilities for mental health, and 26 residential care facilities. More than 200 adult psychiatric beds were available in general hospitals in 2016. Waiting lists for state psychiatric hospitals have fluctuated since 2014. Osawatomie State Hospital, one of the two state psychiatric hospitals, had an average wait time of 1.6 days between June 2015 and July 2016 and a high of 8.0 days in February 2016. In 2014, there was one behavioral health provider per 550 Kansans (1:550), which was near the national average of 1:529. As of December 2016, there were 97 geographical mental health professional shortage areas (HPSAs) identified in Kansas.

Barriers to mental health services reduce or eliminate access to services, and can be personal, systemic or structural. Examples of barriers include waiting lists (which can delay treatment), transportation, lack of insurance or finances, the perception of stigma and a lack of consistent housing. These barriers can result in people forgoing care or having to access care through alternative gateways, (e.g., emergency departments or through the legal system). In 2014, Mental Health America reported that in Kansas 53.3 percent of adults with any mental illness did not receive treatment, 19.6 percent of people with a disability could not see a doctor due to cost, and 56.6 percent of youth with a major depressive episode did not receive mental health services. Mental Health America also reported that six of the ten states with the least access to behavioral health care also have the highest rates of incarceration; Kansas ranked 15th nationally in the number of people incarcerated and 22nd nationally in the access to behavioral health care services.

Key Points

- Kansas expenditures for mental health have shifted from 82 percent in inpatient facilities and 18 percent in the community in 1990, to 25 percent in inpatient facilities and 75 percent in the community now.

- Capacity in state psychiatric hospitals has reduced from more than 1,000 beds in 1990, to 250 beds in 2016 (not including forensic beds, which are reserved for patients who have been charged with or have committed crimes).
- As of December 2016, there were 97 geographical mental health professional shortage areas (HPSA) identified in Kansas.
- In 2014, 19.6 percent of Kansans with disabilities did not visit a doctor due to cost.
- In 2014, there was one behavioral health provider per 550 Kansans (1:550). Behavioral health workforces are as high as 1:200 in Massachusetts to as low as 1:1,200 in Alabama. Nationally, workforces are 1:529.

Mental Health in Kansas

Mental health encompasses emotional, psychological and social well-being. Mental health problems can affect thinking, mood and behavior. Biological factors, life experience and family history can contribute to mental health problems.[1] While there is movement in Kansas and nationally toward more integrated behavioral health care—more seamless care for mental health problems, substance use disorders and addictions, and primary medical care—this report is focused primarily on the mental health system.

Mental health problems can range from mild depression to debilitating mental illnesses that can render a person physically unable to move or speak. These illnesses and disorders are often chronic; however, people can recover from certain conditions with the help of medical and psychosocial interventions. People who cannot fully recover from their conditions can be provided care to keep them as active as possible and give them an improved quality of life.

People with mental health conditions may receive care through the mental health system, which includes organizations and resources providing treatment and supportive services.[2] Conventional access to the mental health system begins through a primary care practice, crisis center or community mental health center where people are assessed and triaged to the appropriate venue for care. Alternative access into the system occurs when conventional access is not available due to lack of transportation, cost, insurance, housing, or some other barrier; or, people enter care through the justice system, emergency rooms, or elect to forgo care.

In Kansas, the mental health system has dramatically changed over the past 30 years. Historically, mental health services were primarily administered in state and private psychiatric hospitals on an inpatient basis. In 1990, the Kansas Mental Health Reform Act fundamentally changed the mental health system in Kansas with the goal of transitioning care from institutional services to community-based care. This was to be accomplished by making community mental health centers the gatekeepers to the state psychiatric hospitals and to community mental health services, which increased the number of patients served in the community and reduced hospital use.[3] The Kansas Mental Health Reform Act provided phased funding to community mental health centers in state hospital catchment areas to enhance screening services, triage or "gatekeeper" services to ensure the patient receives the appropriate services in the appropriate setting. Additionally, the funding was designed to enhance community support services for

adults with severe and persistent mental illness and children with serious emotional disturbances.[4]

With the shift in focus from state psychiatric hospitals to community mental health centers, the number of available public state hospital beds eventually decreased from more than 1,000 beds in 1990 to 250 beds in 2015.[5] The number of total state hospital beds—including forensic beds—has fallen from 705 in 2010 to 451 in 2016.[6] Since community mental health centers became the gatekeepers to access for inpatient beds, more people received treatment through community settings. To further illustrate this shift, community mental health caseloads (number of patients seeking services) increased by 222 percent between 1990 and 1996 as average daily state hospital census declined by 50 percent.[7] With more services being delivered in outpatient settings in the community, the percentage of expenditures in state psychiatric hospitals has declined. Eighty-two percent of services were delivered in inpatient settings and 18 percent in community settings pre-reform; now 75 percent of expenditures occur in community settings and 25 percent in state hospitals (*Figure 1*).

Figure 1. State Mental Health Expenditures by Care Setting, Select Fiscal Years 1990–2014

Year	1990	1996	2008	2010	2012	2014
State Hospitals - Inpatient	82%	49%	28%	25%	24%	25%
Community	18%	51%	68%	71%	75%	75%
Administration	n/a	n/a	4%	4%	<1%	<1%
Total State Mental Health Agency Expenditures	n/a	n/a	$321.7 million	$375.7 million	$385.0 million	$357.6 million
Per Capita State Mental Health Agency Expenditures	n/a	n/a	$115.63	$132.33	$134.49	$124.11

Note: Percentages may not add to 100 percent because of rounding. Values begin in 1990 to illustrate state expenditures pre-Kansas Mental Health Reform Act of 1991. For FY 2008-2014, "Community" includes ambulatory, community, and other 24-hour care, while "Administration" includes agency expenditures for research, training, administration, and other central or regional office expenditures.

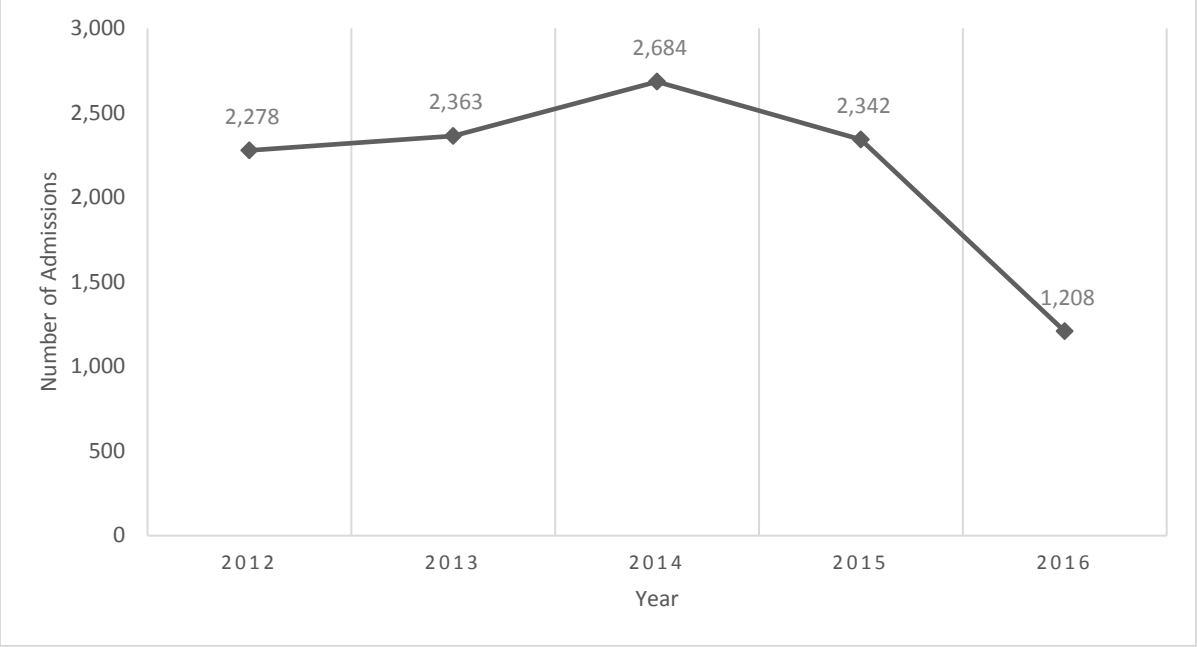
Source: Chamberlin R., Zebley L,. Marty D., Pewewardy N. (1998). Topeka State Hospital Closure Evaluation Final Report (revised) and Substance Abuse and Mental Health Services Administration (SAMHSA) Uniform Reporting System Output Tables.

Because more patients with mental health conditions are being treated in community settings, the need to maintain the same number of state inpatient mental health beds has decreased. However, the equilibrium between supply of inpatient beds and demand for inpatient beds may not have been achieved. To illustrate this, consider the case of one of the two remaining state

mental health facilities in Kansas—Osawatomie State Hospital (OSH). In 2014, OSH began having supply issues when admissions reached a high of 2,684 patients for its 206 licensed beds. That year, the daily census sometimes exceeded 250 patients. Running over maximum capacity led to a series of inspections that identified issues both with care and the facility itself. Under the pressure to renovate and provide better care, OSH suspended voluntary admissions, created waiting lists, and reduced bed capacity to 146 beds (*Figure 2*).

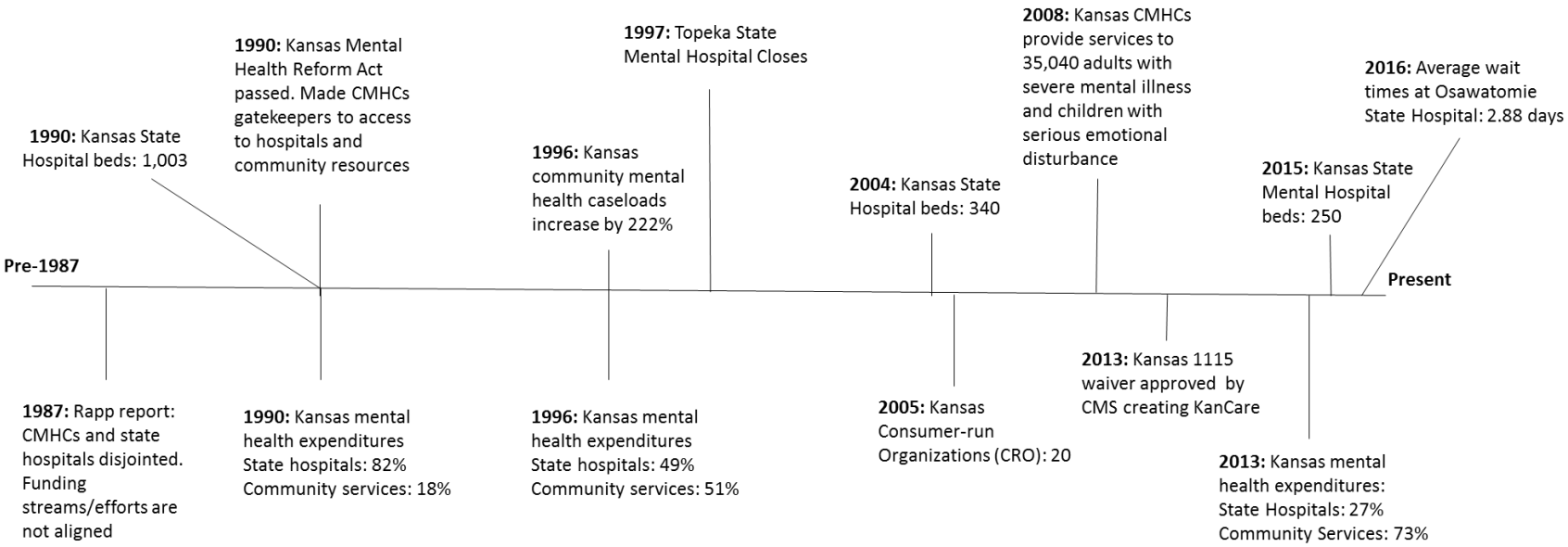
Subsequently, the number of admissions at OSH declined, and the number of people on waiting lists increased. Because of the challenges at OSH, including the loss of federal certification in December 2015, the supply of inpatient psychiatric beds necessary to serve Kansans has been called into question, as well as whether renovating the old facility or building a new facility is the best course of action.

Figure 2. **Osawatomie State Hospital Total Admissions, 2012–2016**



Source: Kansas Department for Aging and Disability Services (KDADS), January 2017.

Figure 3. **Key Events Affecting Kansas Mental Health System, 1987–2017**



Source: KHI's Understanding the Mental Health System in Kansas, 2017.

Kansans with Mental Health Conditions

The Substance Abuse and Mental Health Services Administration (SAMHSA) provides national and state-level reports on behavioral health. In the state prevalence estimates, SAMHSA reports on drug use, tobacco use, serious mental illness, any mental illness, suicidal thoughts and major depressive episodes from data acquired through the National Survey on Drug Use and Health (NSDUH). *Figures 4–7* (pages 5–8) present mental health condition prevalence in Kansas, bordering states (Colorado, Missouri, Nebraska and Oklahoma) and the United States by age. The figures presented are estimates, and unless noted, differences among states and between age groups are not significant. (Confidence intervals for each estimate are available in the source report.)

Figure 4 represents the prevalence of serious mental illness (SMI) by age group and by state. Serious mental illness is defined as having a diagnosable mental, behavioral or emotional disorder, other than a developmental or substance use disorder, that results in serious functional impairment.[8] Nationally, the prevalence of SMI is higher for adults age 18-25 than for adults age 26 and older, but with a smaller sample in Kansas and its bordering states, the difference between age groups is not statistically significant.

Figure 4. Serious Mental Illness (SMI) in Past Year by Age Group and State, 2014-2015

State	Age		
	Adults 18+	Adults 18-25	Adults 26+
Kansas	4.1%	5.0%	3.9%
Colorado	4.3%	5.3%	4.1%
Missouri	4.7%	5.6%	4.5%
Nebraska	4.4%	5.7%	4.2%
Oklahoma	4.3%	5.0%	4.2%
Total United States	4.1%	4.9%	3.9%

Source: SAMHSA National Survey on Drug Use and Health (NSDUH), 2014–2015.

Figure 5 represents any mental illness (AMI) by age group and by state. Any mental illness is defined as having a diagnosable mental, behavioral or emotional disorder, other than a developmental or substance use disorder. Mild, moderate and serious mental illnesses are included in AMI. Nationally and in Colorado, the prevalence of AMI is higher for adults age 18-25 than for adults age 26 and older, but in Kansas, Missouri, Nebraska and Oklahoma, the difference is not statistically significant.

Figure 5. **Any Mental Illness in Past Year by Age Group and State, 2014-2015**

State	Age		
	Adults 18+	Adults 18-25	Adults 26+
Kansas	17.5%	19.2%	17.2%
Colorado	19.6%	24.3%	18.8%
Missouri	18.0%	21.0%	17.5%
Nebraska	18.2%	20.0%	17.9%
Oklahoma	19.2%	20.6%	18.9%
Total United States	18.0%	20.9%	17.5%

Source: SAMHSA National Survey on Drug Use and Health (NSDUH), 2014-2015.

Figure 6 (page 7) describes suicidal ideation, or having thoughts of suicide, by age group and state. To measure thoughts of suicide, the question "At any time in the past 12 months, did you seriously think about trying to kill yourself?" was asked. The highest rate of Kansas adults who reported having serious suicidal thoughts was among the group age 18–25, significantly higher than for adults age 26 and older. Similarly, adults age 18-25 in the states bordering Kansas and in the United States as a whole had higher rates of suicidal thoughts than adults age 26 and older.

Figure 6. Had Serious Thoughts of Suicide in the Past Year by Age Group and State, 2014–2015

State	Age		
	Adults 18+	Adults 18-25	Adults 26+
Kansas	4.1%	7.9%	3.5%
Colorado	4.5%	8.6%	3.8%
Missouri	3.9%	7.7%	3.3%
Nebraska	4.2%	8.3%	3.5%
Oklahoma	4.0%	7.7%	3.3%
Total United States	4.0%	7.9%	3.3%

Source: SAMHSA National Survey on Drug Use and Health (NSDUH), 2014-2015.

Figure 7 (page 8) represents the prevalence of a Major Depressive Episode (MDE) in the past year by age group and by state. An MDE is defined as "a period of at least two weeks when an individual experienced a depressed mood or loss of interest or pleasure in daily activities and had a majority of specified depression symptoms." Kansas adults age 18-25 were more likely to have an MDE than adults age 26 and older. Results were similar in the United States as a whole.

MDE is also reported for adolescents age 12-17; however, there are minor wording differences in the questions asked of adults and adolescents in the survey, so data were not combined. The rate of MDE for Kansas adolescents age 12-17 was similar to the rate for adolescents in bordering states and the United States as a whole.

Figure 7. Major Depressive Episode in Past Year by Age Group and State, 2014–2015

State	Age			
	Adolescents 12-17	Adults 18+	Adults 18-25	Adults 26+
Kansas	11.2%	7.0%	9.8%	6.5%
Colorado	13.7%	7.3%	10.5%	6.7%
Missouri	11.5%	6.6%	9.7%	6.1%
Nebraska	12.3%	7.2%	10.8%	6.6%
Oklahoma	12.6%	6.8%	9.5%	6.4%
Total United States	11.9%	6.6%	9.8%	6.1%

Source: SAMHSA National Survey on Drug Use and Health (NSDUH), 2014–2015.

Mental Health Facilities in Kansas

In Kansas, the Kansas Department for Aging and Disability Services (KDADS) is responsible for administering and maintaining the state behavioral health system and has classified the mental health facilities in the state into the following categories:[9]

- Consumer-run organizations;
- Community mental health centers (CMHC);
- Community crisis centers;
- State and private psychiatric hospitals;
- Psychiatric residential treatment facilities;
- Nursing facilities for mental health; and
- Residential care facilities.

Important characteristics of mental health facilities are the number of facilities, how they are staffed, what services they provide, which patients they serve and whether the facility is an inpatient, outpatient or a facility that provides both.

Figure 8 (pages 9 and 10), outlines the characteristics of each type of facility in the Kansas mental health system. (Note: It does not include substance use treatment centers or outpatient opioid treatment clinics, which are also licensed by KDADS; however, some mental health providers can be dually licensed to treat substance use disorders.) Consumer-run organizations and residential care facilities are best suited for low-severity patients looking for support to stay in their communities. Crisis centers and community mental health centers (CMHCs) are both entry points into the mental health system and can screen and triage all severity of patients, but are designed for outpatient or short-term stabilization services and not for extended stays. Psychiatric hospitals and nursing facilities for mental health treat medium- and high-acuity patients on an inpatient basis, and psychiatric residential treatment facilities serve children and adolescents. A map of the facilities (*Figure 9,* page 11) is based on the KDADS *Directory of Mental Health Resources in Kansas*.

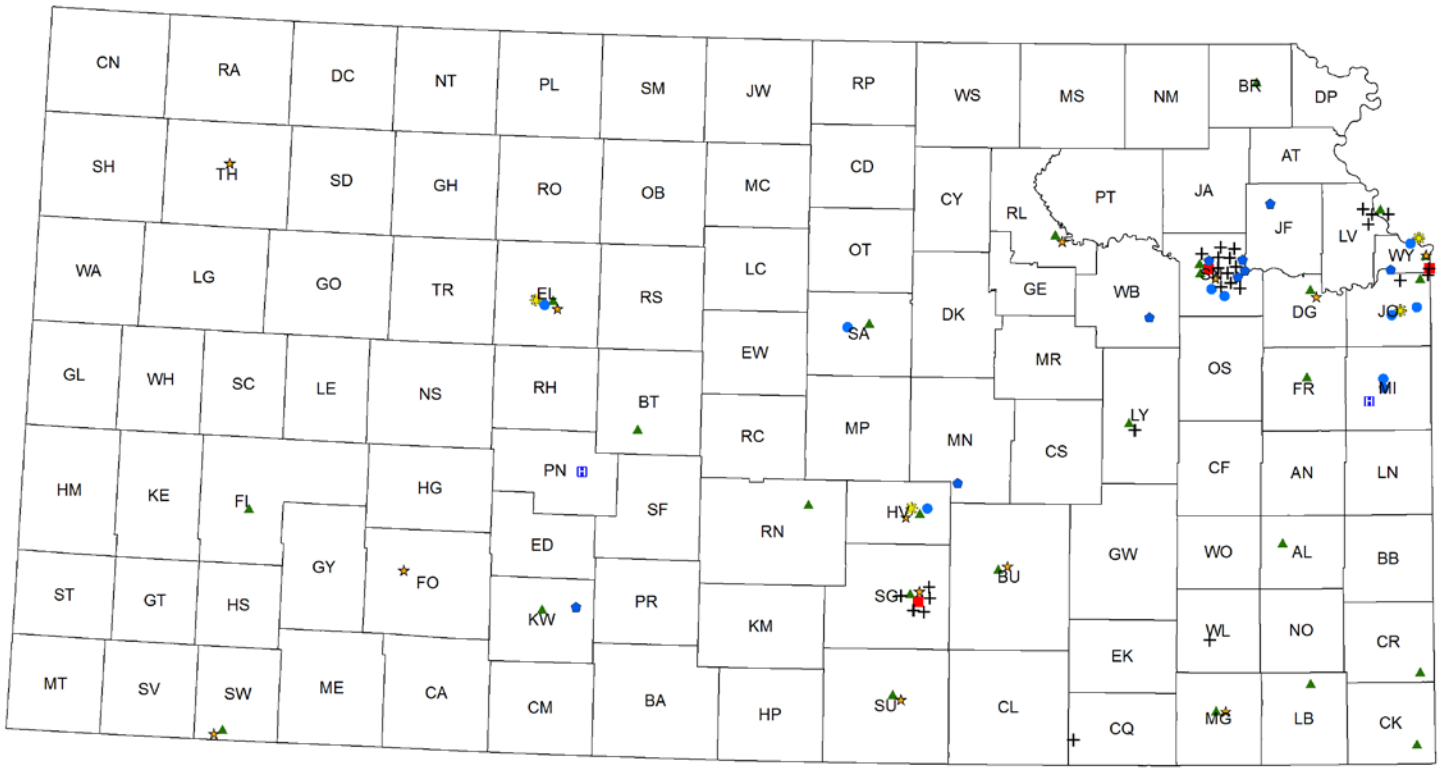
Figure 8. **Characteristics of Behavioral Health Facilities in Kansas, 2015**

Facility Type	Description	Number of Facilities	Staffing / Availability	Services Provided	Patient Condition Severity	Inpatient / Outpatient
Consumer Run Organizations (CROs)	Peer-led support organizations which help people with mental health issues live independent lives.	13	Staffed by people with behavioral illness. Open limited hours per week, vary by facility.	• Peer support services; • Employment services; • Insurance assistance; and • Health and wellness activities.	Low	Outpatient
Community Mental Health Centers (CMHCs)	Provides the community-based public mental health services safety net.	26	Nurses, social workers, mental health professionals, psychiatrists and medical doctors—24-hour support.	• Outpatient services for adults; • Outpatient services for children; • Behavioral health screening for patients; and • Must accept all patients.	Low Medium High	Outpatient
Community Crisis Centers	Provides short-term stabilization for people in mental health crisis.	3	Nurses, addiction counselors, peer support, recovery coaches, triage specialists.	• 24-hour assessment and triage; • Crisis observation; • Short-term crisis stabilization; and • Sobering bed.	Low Medium High	Outpatient and inpatient stabilization (up to 3 days)

Facility Type	Description	Number of Facilities	Staffing / Availability	Services Provided	Patient Condition Severity	Inpatient / Outpatient
State and Private Psychiatric Hospitals	Designed to protect people in danger to themselves or others.	State (2) Private (4)	Broad range of mental health providers, clinical providers.	• Detox care; • Preventing/ managing symptoms; • Crisis stabilization, successful living; and • Sexual predator treatment.	Medium High	Inpatient Average length of stay for Osawatomie State Hospital in 2016: 43 days
Psychiatric Residential Treatment Facilities (PRTFs)	Provide out-of-home residential psychiatric treatment to children/ adolescents.	9	Nurses, counselors, psychologists, and psychiatrists.	• Strengths-based; • Culturally competent; • Trauma-informed; and • Medically appropriate treatments.	Low Medium High	Inpatient
Nursing Facilities for Mental Health (NFMH)	Provide residential care and rehabilitation treatment for persons experiencing severe symptoms of mental illness.	10	Nurses, social workers, mental health technicians, psychiatrists, medical doctors.	• Residential care and rehabilitation; • Round-the-clock supervision available.	High	Inpatient
Residential Care Facilities	Provide housing and support to persons with mental illness who need housing and/or support to live in community.	26	Staff available 24-hours. Primarily non-clinical staff to assist with daily tasks.	• No treatment services provided for mental health conditions. • Patients receive treatment through CMHCs or other outpatient options.	Low	Long-term assisted living

Note: There are 15 general hospitals in Kansas that have child, adult or geriatric inpatient psychiatric beds.
Source: Kansas Department for Aging and Disability Services, 2017.

Figure 9. Mental Health Resources in Kansas, 2017



Facility Type

- Community Crisis Center
- Community Mental Health Center
- Consumer Run Organization
- Nursing Facility for Mental Health
- Private Psychiatric Facility
- Psychiatric Residential Treatment Facility
- Residential Care Facility
- State Mental Health Hospital

Note: Does not capture 15 general hospitals with child, adult or geriatric inpatient psychiatric beds.
Source: Kansas Department for Aging and Disability Services, "Directory of Mental Health Resources in Kansas", 2017.

In addition to the types of mental health facilities available, it is important to understand the demographic characteristics of people receiving treatment in the community and in state psychiatric hospitals. This is important because people receiving treatment in state hospitals generally have more severe conditions that require more intensive care. *Figure 10* illustrates the age and gender of people receiving treatment in the community and in state hospitals in Kansas. Most people receiving care in either setting are between age 21 and 64. More patients receiving treatment in the state hospitals are male, and slightly more than half of the patients receiving treatment in the community are female. Roughly 46 of every 1,000 people living in Kansas receive mental health services in a community setting, and just less than one of every 1,000 people receive treatment in state hospitals. *Figure 11* (page 13) illustrates that of the total number of adults and children receiving services in the community or in state hospitals in 2016, 78 percent were white, and 93 percent reported an ethnicity of not Hispanic or Latino.

Figure 10. **People Receiving Mental Health Services in Community Settings and State Psychiatric Hospitals in Kansas by Gender and Age, Fiscal Year 2016**

	Community Setting	State Hospitals
Number of People	133,247	2,406
Rate / 1,000	45.8	0.8
Gender		
Male, %	47.0%	66.3%
Female, %	52.2%	33.7%
Age		
0–17	26.8%	0%
18–20	6.2%	5.7%
21–64	60.9%	90.9%
65+	5.3%	3.4%

Note: Gender or age not reported for some consumers, so figures may not add to 100 percent.

Source: Kansas Mental Health National Outcome Measures (NOMS): SAMHSA Uniform Reporting System, 2016.

Figure 11. **Characteristics of Persons Served in Community Settings and State Hospitals in Kansas, Fiscal Year 2016**

Demographics	Number	Percentage
Race		
American Indian / Alaskan Native	3,944	3.0%
Asian	1,208	0.9%
Black / African American	11,008	8.3%
Native Hawaiian / Pacific Islander	278	0.2%
White	103,954	78.0%
Multi-racial	3,315	2.5%
Not Available	9,540	7.2%
Ethnicity		
Hispanic or Latino	8,285	6.2%
Not Hispanic or Latino	123,506	92.7%
Not Available	1,456	1.1%

Note: Percentages may not add to 100 percent because of rounding.
Source: Kansas Mental Health National Outcome Measures (NOMS): SAMHSA Uniform Reporting System, 2016.

Mental Health System Workflow

The mental health system workflow is the process of evaluating a patient, assessing his or her needs, and then connecting the patient to the right services in the most appropriate facility. When this happens, the patient gets the treatment needed, and the mental health system runs efficiently and effectively. However, there are cases where workflow breaks down due to cost, access or other barriers, and people do not receive the care they need or receive care in suboptimal settings.

To illustrate the conventional mental health system workflow, consider a person who enters the system through a crisis stabilization center. After the person presents at the crisis center, he or she is triaged and an assessment is performed to ascertain health needs. The patient is then stabilized over a short period (typically less than three days) and then discharged. At the time of discharge, the patient is referred to follow-up services based on assessed needs. If the patient requires a high level of care, a referral to a psychiatric facility for more intensive inpatient care may be provided. If the patient has less-intensive needs, a referral may be made to an outpatient provider or a consumer-run organization. The goal of the mental health system is to re-integrate

the patient back into the community, and if that is not possible due to the severity of his or her condition, align the patient with the most appropriate long-term support.

Alternative Gateways into the Mental Health System

Alternative gateways into the mental health system include emergency departments and interaction with law enforcement.

Emergency departments provide emergency medical services. A recent study by the Agency for Healthcare Research and Quality (AHRQ) reported that between 2006 and 2013, emergency department visits increased by 55 percent for depression, anxiety or stress conditions, 52.0 percent for psychoses or bipolar disorders, and 37.0 percent for substance abuse disorders.[10] Emergency departments can treat behavioral health symptoms and can provide referrals to other community resources; however, if access barriers (e.g., cost, insurance or transportation) exist for patients, they may continue to use emergency departments as their usual source of care.

Untreated mental illness can lead to interactions with law enforcement. People with mental illnesses are more likely to be victims of crime than people without mental illnesses. Interaction with law enforcement can also occur if individuals with untreated mental illnesses behave erratically or with aggression, or if they are charged with crimes including nonviolent "survival" offenses such as theft or vagrancy.

In a recent study published in the American Journal of Men's Health, people incarcerated in jails are five times as likely to suffer from depression, three and a half times as likely to have life dissatisfaction, and four times as likely to have recent drug use compared to those not incarcerated.[11] Mental Health America (a national community-based nonprofit dedicated to addressing the needs of those living with mental illness and to promoting the overall mental health of all Americans) examined the relationship between access to behavioral health services and incarceration in 2014 and found that six of the 10 states with the least access to behavioral health care also have the highest rates of incarceration (e.g., Alabama, Arkansas, Mississippi, Texas, Georgia and Florida).[12] In 2014, Mental Health America ranked Kansas 15th overall in number of people incarcerated (322 per 100,000) and 22nd nationally in access to behavioral health care services.[13] Mental Health America assessed the adequacy of access to care by measuring patients with disabilities who did not access health services due to cost (Kansas: 19.6

percent), mental health provider ratios per resident (Kansas: 1:550) and seven other behavioral health access metrics displayed in *Figure 12*.[14]

Figure 12. **Behavioral Health Access Metrics, Kansas and United States, 2014**

Behavioral Health Metric	Kansas (Rank)	United States
Adults with Any Mental Illness (AMI) who did not receive treatment	53.3% (20)	56.5%
Adults with AMI reporting unmet need	22.7% (38)	20.3%
Adults with AMI who are uninsured	17.4% (30)	17.0%
Adults with disability who could not see a doctor due to costs	19.6% (18)	22.9%
Youth with major depressive episode (MDE) who did not receive mental health services	56.6% (12)	64.1%
Youth with severe MDE who received some consistent treatment	29.6% (10)	21.7%
Children with private insurance that did not cover mental or emotional problems	5.9% (14)	7.9%
Students identified with emotional disturbance for an individualized education program	5.3% (39)	7.7%
Mental health workforce availability	550:1 (28)	529:1

Source: Mental Health America, Mental Health in America-Access Care Data, 2014.

Kansas has implemented statewide and local programs to help people with behavioral health needs who have minor law infractions receive care, rather than be incarcerated. Examples include crisis intervention training (CIT) program and specialized courts for non-violent drug offenders, people with mental health conditions, and veterans. Crisis intervention training is a nationally recognized training program for police officers to aid in the legal interactions with people with behavioral health conditions. Kansas implemented a CIT training program based on recommendations made by the Kansas Governor's Mental Health Task Force in 2014. Crisis intervention training can help first-line responders and ensure that people end up in the appropriate setting whether it be a legal, mental or clinical facility. The state of Kansas recently hired a crisis intervention training/veterans affairs program coordinator to continue to grow and develop the CIT program.

The specialized court programs are designed to keep veterans and people with substance abuse disorders or mental health conditions out of jails and prisons. These courts provide diversion for

simple possession of controlled substances or minor non-violent infractions and help people receive treatment, pay their fines, serve community service and remain in the community. Specialized courts have been estimated to improve quality of life, reduce recidivism and save taxpayer dollars that would have gone to keeping non-violent offenders in jails and prisons.[15]

Barriers to Mental Health Access

Barriers are personal, systemic or structural obstacles preventing people from connecting to the appropriate health resources. Barriers to mental health access include delays in services due to waiting lists, unavailable or unreliable transportation, lack of insurance or financial stability, lack of stable housing, and cultural, language and attribution barriers.

Waiting Lists

Waiting lists are required when there is a demand for services and there is no immediate availability due to capacity limitations. Based on a report from the Treatment Advocacy Center in 2016, there could be a shortage of psychiatric inpatient beds as high as 123,300 beds nationally.[16] This number was based on a recommended 40 psychiatric inpatient beds per 100,000 people. The PEW Charitable Trusts Foundation in 2016 reported there were 451 state inpatient beds available in Kansas (including civil and forensic beds) which would equate to a 15.5 bed per 100,000-person ratio in the state.[17]

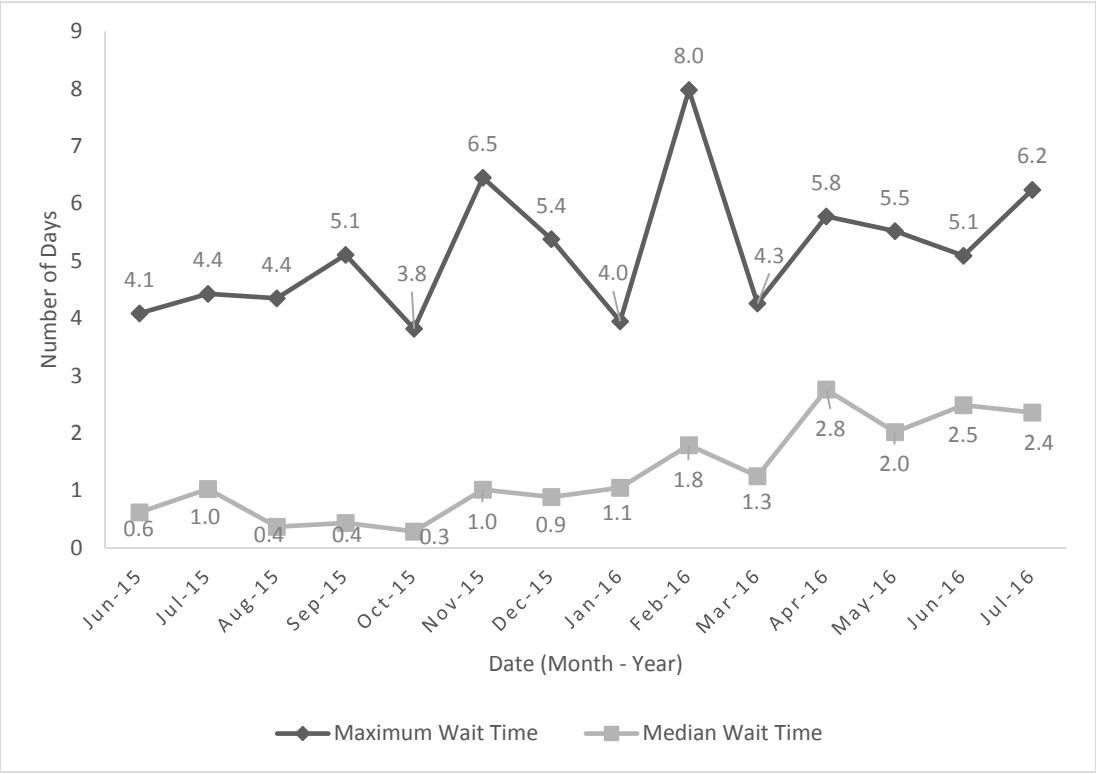
In data provided by the Kansas Department for Aging and Disability Services (KDADS) and represented in *Figure 13* (page 17), people on waiting lists for Osawatomie State Hospital had an average wait time of 1.6 days between June 2015 and July 2016, and a high of 8.0 days in February 2016. During this time, 2,100 people were on the waiting list, 1,333 were admitted, 748 were diverted to another hospital or venue for care, and the remaining 19 were waiting for admission or diversion.

Shawnee Mission Health, a medical center in Johnson County, tracked referrals for involuntary psychiatric holds from January to April in 2015 and January to April in 2016 and reported that the average hold time for patients increased from 9.4 hours in 2015 to 44.4 hours in 2016.

When patients with inpatient psychiatric needs are waiting in hospitals and emergency rooms, the patient and the facility are affected. According to the American College of Emergency Physicians (ACEP), psychiatric holds can be problematic for hospital emergency departments and

can negatively affect patient quality of care, hospital operations and the health system's finances.[18]

Figure 13. Osawatomie State Hospital Wait Times, June 2015–July 2016



Source: KHI analysis of data provided by Kansas Department for Aging and Disability Services, 2017.

Transportation Barriers

Transportation barriers can impede a patient's ability to access mental health services, especially if they live in areas that have shortages of mental health professionals and/or do not have access to reliable transportation. According to KDHE, as of December 2016, Kansas has 97 geographic mental health professional shortage areas (HPSA).[19] To be defined as a HPSA, an area must: (1) be a rational service area for the delivery of care; (2) Have a population-to-psychiatrist ratio greater than or equal to 30,000:1; or (3) have mental health professionals in a contiguous area that is over-utilized, excessively distant or inaccessible to residents of the area in consideration.

In areas that are not short on mental health professionals, transportation can still be a barrier if public transportation options do not exist, public transportation routes do not go near a provider, or if the person does not have access to other sources of reliable transportation.

Insurance/Financial Barriers

Insurance and financial barriers can affect access to mental health services. Financial barriers can include not being able to afford insurance, treatment or medications to help manage mental health conditions. Being uninsured or under-insured (when insurance does not cover needed services, or has high out-of-pocket costs) can restrict access to mental health providers or facilities and make access to services cost-prohibitive. Also, in the case of people with Medicaid coverage, they are subject to the Medicaid Institution for Mental Diseases (IMD) exclusion, which can significantly affect access to behavioral health services. The IMD exclusion prohibits the use of federal monies through Medicaid for any care (including medical services) provided to patients age 22 to 64 in mental health or substance abuse residential treatment facilities with more than 16 beds. The IMD exclusion limits access to inpatient services and restricts innovation.

IMD Exclusion

The Medicaid Institution for Mental Diseases (IMD) exclusion prohibits the use of federal Medicaid financing for care provided to most patients age 22-64 in mental health facilities with more than 16 beds.

- Social Security Act Section 1905(a)(B)

Housing Barriers

Homelessness and lack of reliable housing affect a person's stress level, ability to attend appointments and maintain a mentally healthy lifestyle. Having stable housing is also critical to transitioning in and out of short-term or long-term behavioral health facilities or participating in peer support groups. According to the U.S. Department of Housing and Urban Development, an estimated 26 percent of homeless adults staying in shelters have a serious mental illness, and an estimated 46 percent live with severe mental illness and/or substance use disorders.[20] Additionally, Rainbow Services, Inc. (RSI), in Kansas City, Kansas, has identified homelessness and substance abuse as common factors among patients who use the crisis stabilization services frequently.[21] Absence of reliable housing is also a barrier to access to public assistance programs, as an in-state address is required to enroll.

Cultural, Language and Attribution Barriers

Miscommunication between a clinician and a patient can occur if the clinician and the patient come from different cultural backgrounds, even if they speak the same language. Research has reported that overt and subtle forms of miscommunication and misunderstanding can lead to misdiagnosis, conflicts over treatment, and poor adherence to a treatment plan.[22] In the case where patient and clinician do not speak the same language or have the same cultural background, these problems intensify.

Differences also exist between cultures in attributing meaning or cause to a behavior or event. Research has reported some individuals perceive that people who receive behavioral health services are a danger to themselves and others, are violent and prone to outbursts, and have genetic deficiencies.[23] Further, individuals receiving behavioral health services can feel more shame about receiving treatment than receiving medical treatment for chronic diseases including asthma and attention deficit hyperactivity disorder (ADHD).[24]

Efforts have been made to address cultural differences and de-stigmatize mental illness through education and promotion of mental health services, but culture, language and attribution remain as barriers to individuals seeking treatment.

Strategies to Address Gaps in the Kansas Mental Health System

Access to crisis care, health insurance parity, integration of mental health services with primary medical care and access to mental health services are all gaps within the Kansas mental health system. These gaps have been identified based on reported outcomes and by programs that have been implemented in Kansas that have identified or improved a gap in service. The following set of strategies is not all-inclusive but is offered as a resource for further study.

Gap: Access to Crisis Care

Identification: Growing waiting lists at state institutions and patients using the emergency departments for crisis care.

Benefit: Crisis care can reduce demand on state institutions and emergency departments.

Example of success: Kansas Rainbow Services, Inc. (RSI)

Rainbow Mental Health Center in Kansas City, Kan., originally was a 50-bed inpatient hospital operated by the state. In 2014, RSI re-opened as a 10-bed, community crisis-stabilization inpatient center with an outpatient sobering area and an observation station designed for a maximum stay of 23 hours. From April 2014 to August 2016, RSI absorbed 4,543 admissions from 2,480 individuals with mental illnesses who otherwise would have gone to a state hospital, emergency department or jail.[25] In 2015 alone, it has been estimated that RSI saved $4 million in state hospital costs, $2 million in emergency room visits, and $75,000 in jail expenses.[26]

Gap: Insurance Coverage

Definition: Insurance coverage is a gap in terms of access to affordable insurance and having insurance parity. The National Alliance on Mental Illness defines mental health insurance parity as "the equal treatment of mental health conditions and substance use disorders in insurance plans".[27] That would mean if an insurance plan provides access to primary or disease-specific services, it should also include the same level of support for mental health services.

Identification: 19.6 percent of adult Kansans with disabilities did not visit a doctor due to cost, and 17.4 percent of adults with AMI are uninsured.[28]

Benefit: Having access to health insurance provides greater access to mental health resources. Additionally, health insurance parity means that coverage of behavioral health services is on the same terms and conditions as other types of medical care.

Example of success: Connecticut enacted SB 1085 to clarify that individual health plans must cover behavioral health conditions (anxiety and depression) and that behavioral health is required to be included in health plan compliance surveys and consumer report cards.[29] New York and California have implemented similar legislation.[30] The state of Ohio, which expanded Medicaid under Governor John Kasich, has reported that 500,000 previously uninsured, low-income Ohio adults have received mental health and addiction services.[31] In 2016, the Centers for Medicare and Medicaid Services (CMS) released a new rule allowing Medicaid reimbursement for some short-term inpatient stays in otherwise-excluded Institutions of Mental Diseases (IMD), but only if offered through a Medicaid managed care plan.[32] Kansas has comprehensive managed care for nearly all Medicaid enrollees, but constraints in the rule (including a hard limit on the length of admissions) have to date kept the state from using the exception. Other options include seeking a waiver of the IMD exclusion.

Gap: Integrating Behavioral Health and Primary Medical Care Services

Identification: Nationally, 70 percent of all primary care visits involve a mental health concern.[33] Kansas has identified 97 mental health-related health professional shortage areas (HPSAs) without sufficient access to mental health resources.[34]

Benefit: Physically integrating mental health resources with primary medical care enables the patient to receive whole-person care in a single facility or system, and provides another pathway to receiving mental health services.

Example of success: In Kansas, a partnership between COMCARE, a community mental health center, and GraceMed, a federally qualified health center (FQHC), created one of the first physically integrated primary medical and behavioral health facilities in the state. They implemented a "reverse co-location" model in which GraceMed established and staffed a small FQHC inside the COMCARE facility so patients could receive services in one location.

Screening, Brief Intervention, Referral for Treatment (SBIRT) is an evidence-based approach of identifying patients who use alcohol and other drugs at risky levels, with the intention of reducing and preventing related health-consequences, disease, accidents and injuries. It is not limited to only behavioral health settings; approved service locations also include medical practices, hospitals, safety net clinics, and long-term care providers.[35] SBIRT is a reimbursable service in the KanCare program.

Two policy innovations which supported physical integrated systems were passed in Oregon and Arizona. Oregon enacted SB 832 to develop standards for integrating behavioral and clinical health services in patient-centered medical homes and behavioral health homes.[36] Arizona passed SB 1283 that develops standards for co-location of clinical and behavioral health services.[37]

Gap: Access to Mental Health Services

Identification: KDHE has identified 97 geographic mental health HPSA's without enough providers or resources to serve communities.[38]

Benefit: Access to routine mental health services can help prevent unnecessary use of emergency department or inpatient services.

Examples of success: In SB 5175, Washington established criteria for health plans to reimburse for telehealth and telemedicine expenses.[39] Tennessee enacted HB 699 to provide protections for providers delivering care through telehealth services.[40] The Veterans Administration enacted a telehealth program that demonstrated clinically significant improvements in post-traumatic stress disorder (PTSD) symptoms from pre- to post-treatment periods for people living in rural areas without access to behavioral health services.[41] Telemedicine is reimbursable in KanCare, but while it is typically covered by private insurers, conditions for reimbursement vary by payer.

Summary

The mental health system in Kansas is a network of public and private resources and facilities designed for high- and low-acuity patients. Mental health services in Kansas have shifted from being delivered primarily in inpatient settings to community outpatient settings since the early 1990s, and that trend continues. Conventional access into the mental health system begins through a primary care practice, crisis center or community mental health center, where people are assessed and triaged to the appropriate venue for care. Alternative access into the mental health system occurs when traditional access is not available due to availability of transportation, cost, insurance, housing, or some other barrier, or people enter care through the justice system, emergency rooms, or elect to forgo care. Gaps in service exist in all systems, but understanding how Kansas and other states have addressed gaps in mental health services through policy, legislation and programs can help policymakers develop new interventions to improve the system.

Appendix A: Endnotes

1. United States Department of Health and Human Services (HHS). *What is Mental Health?* Retrieved October 2017, from https://www.mentalhealth.gov

2. Substance Abuse and Mental Health Services Administration (SAMHSA). *Behavioral Health Treatment and Services.* Retrieved February 15, 2017, from https://www.samhsa.gov/treatment

3. Lee, R., Chamberlin, R., & Rapp, C. (2001). System Effects of The Kansas Mental Health Reform Act of 1991. *Community Mental Health Journal*, *37* (5), 437-445.

4. Ibid.

5. Kansas Mental Health Coalition. (2016). *Testimony presented to the Special Committee on Osawatomie and Larned State Hospital Delivered December 19-20, 2016.* Retrieved February 1, 2017, from http://www.kslegislature.org/li_2016/b2015_16/committees/ctte_spc_2016_special_committee_on_larned_and_os_1/documents/testimony/20161219_26.pdf

6. Fuller, D., Sinclair, E., Geller, J., Quanbeck, C., & Snook, J. (2016). Going, Going Gone. Trends and Consequences of Eliminating State Psychiatric Beds, 2016. *Treatment Advocacy Center*. Retrieved on February 15, 2017, from http://www.treatmentadvocacycenter.org/storage/documents/going-going-gone.pdf

7. Chamberlain R., Zebley L., Marty D., & Pewewardy N. (1998). *Topeka State Hospital Closure Evaluation: Final Report (Revised).* Lawrence, KS: School of Social Welfare. University of Kansas.

8. Substance Abuse and Mental Health Services Administration (SAMHSA). *Behind the Term: Serious Mental Illness.* Retrieved February 15, 2017, from http://www.nrepp.samhsa.gov/Docs/Literatures/Behind_the_Term_Serious%20%20Mental%20Illness.pdf

9. Kansas Department for Aging and Disability Services. (2017). Data aggregated from KDADS website and provided by KDADS personnel. Retrieved on February 15, 2017, from https://www.kdads.ks.gov

10. Weiss, A., Barrett, M., Heslin, K., & Stocks, C. (2016). Trends in Emergency Department Visits Involving Mental and Substance Use Disorders, 2006–2013. *Agency for Healthcare Research and Quality, Statistical Brief #216*. Retrieved on February 15, 2017, from https://www.hcup-us.ahrq.gov/reports/statbriefs/sb216-Mental-Substance-Use-Disorder-ED-Visit-Trends.pdf

11. Yi, Y., Turney, K., & Wildeman, C. (2016). Mental Health Among Jail and Prison Inmates. *American Journal of Men's Health*, 1557988316681339.

12. Mental Health America. Retrieved February 1, 2017, from http://mentalhealthamerica.net/

13. Ibid.

14. Ibid.

15. Fuchs, J.,& Spencer, M. (2011). Review of the Sedgwick County (Wichita), Kansas District Court Drug Court Program. *American University, School of Public Affairs, Justice Programs Office*. Retrieved on February 1, 2017, from http://jpo.wrlc.org/bitstream/handle/11204/2058/Review%20of%20the%20Sedgwick%20County%20Wichita%20Kansas%20District%20Court%20Drug%20Court%20Program.pdf;sequence=3

16. Fuller, D., Sinclair, E., Geller, J., Quanbeck, C.& Snook, J. (2016). Going, Going Gone. Trends and Consequences of Eliminating State Psychiatric Beds, 2016. *Treatment Advocacy Center*. Retrieved on February 1, 2017, from http://www.treatmentadvocacycenter.org/storage/documents/going-going-gone.pdf

17. Ollove, M. (2016, August 02). Amid Shortage of Psychiatric Beds, Mentally Ill Face Long Waits for Treatment. *PEW Charitable Trusts.* Retrieved February 1, 2017, from http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2016/08/02/amid-shortage-of-psychiatric-beds-mentally-ill-face-long-waits-for-treatment

18. American College of Emergency Physicians. (2014). *Care of the Psychiatric Patient in the Emergency Department – A Review of the Literature*. Retrieved February 1, 2017, from https://www.acep.org/uploadedFiles/ACEP/Clinical_and_Practice_Management/Resources/Mental_Health_and_Substance_Abuse/Psychiatric%20Patient%20Care%20in%20the%20ED%202014.pdf

19. Kansas Department of Health and Environment. (2016). *Federal Mental Health Professional Shortage Areas*. Retrieved February 1, 2017,, from http://www.kdheks.gov/olrh/sd_resources/Federal%20Mental%20HPSA%20Background_D ec2016.pdf

20. U.S. Department of Housing and Urban Development, Office of Community Planning and Development. (2011). *The 2010 Annual Homeless Assessment Report to Congress.* Retrieved January 16, 2015, from https://www.hudexchange.info/resources/documents/2010HomelessAssessmentReport.pdf

21. Marso, A. (2016, November 16). *Leader of KCK Mental Health Center Touts Savings from Care. KCUR.* Retrieved February 15, 2017, from http://kcur.org/post/leader-kck-mental-health-center-touts-savings-care#stream/0

22. Office of the Surgeon General (U.S.); Center for Mental Health Services (U.S.); National Institute of Mental Health (U.S.). *Mental Health: Culture, Race, and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General*. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2001 Aug. *Chapter 2 Culture Counts: The Influence of Culture and Society on Mental Health*. Retrieved February 15, 2017, from: https://www.ncbi.nlm.nih.gov/books/NBK44249/

23. Parcesepe, A, & Cabassa, L. (2013). Public stigma of mental illness in the United States: a systematic literature review. A*dministration and Policy in Mental Health and Mental Health Services Research, 40*(5), 384–399.

24. Ibid.

25. Marso, A. (2016, November 16). *Leader of KCK Mental Health Center Touts Savings from Care. KCUR.* Retrieved February 15, 2017, from http://kcur.org/post/leader-kck-mental-health-center-touts-savings-care#stream/0

26. Ibid.

27. National Alliance on Mental Illness. *What is Mental Health Parity?* Retrieved February 15, 2017, from http://www.nami.org/Find-Support/Living-with-a-Mental-Health-Condition/Understanding-Health-Insurance/What-is-Mental-Health-Parity

28. Mental Health America. *Mental Health in America – Access to Care Data.* Retrieved February 1, 2017, from http://www.mentalhealthamerica.net/issues/mental-health-america-access-care-data

29. National Alliance on Mental Illness (NAMI). (2015). *State Mental Health Legislation 2015 Trends Themes and Effective Practices*. Retrieved February 15, 2017, from https://www.nami.org/About-NAMI/Publications-Reports/Public-Policy-Reports/State-Mental-Health-Legislation-2015/NAMI-StateMentalHealthLegislation2015.pdf

30. Ibid.

31. Candisky, C., & Johnson, A. (2016, July 17). Medicaid expansion covers nearly 500,000 Ohioans for mental health, drug treatment. *The Columbus Dispatch*. Retrieved February 20, 2017, from http://www.dispatch.com/content/stories/local/2016/07/17/medicaid-expansion-covers-nearly-500000-for-mental-health-drug-treatment.html

32. National Association of Psychiatric Health Systems (2016). *Medicaid Managed Care Final Rule.*

33. National Alliance on Mental Illness (NAMI). (2015). *State Mental Health Legislation 2015 Trends Themes and Effective Practices*. Retrieved February 15, 2017, from https://www.nami.org/About-NAMI/Publications-Reports/Public-Policy-Reports/State-Mental-Health-Legislation-2015/NAMI-StateMentalHealthLegislation2015.pdf

34. Kansas Department of Health and Environment (KDHE). (2016). *Federal Mental Health Professional Shortage Areas*. Retrieved February 1, 2017, from http://www.kdheks.gov/olrh/sd_resources/Federal%20Mental%20HPSA%20Background_Dec2016.pdf

35. Kansas Department for Aging and Disability Services. *Screening, Brief Intervention, Referral for Treatment.* Retrieved from https://www.kdads.ks.gov/provider-home/providers/sbirt

36. National Alliance on Mental Illness (NAMI). (2015). *State Mental Health Legislation 2015 Trends Themes and Effective Practices*. Retrieved February 15, 2017, from https://www.nami.org/About-NAMI/Publications-Reports/Public-Policy-Reports/State-Mental-Health-Legislation-2015/NAMI-StateMentalHealthLegislation2015.pdf

37. Ibid.

38. Kansas Department of Health and Environment. (2016). *Federal Mental Health Professional Shortage Areas*. Retrieved February 1, 2017, from http://www.kdheks.gov/olrh/sd_resources/Federal%20Mental%20HPSA%20Background_Dec2016.pdf

39. National Alliance on Mental Illness (NAMI). (2015). *State Mental Health Legislation 2015 Trends Themes and Effective Practices*. Retrieved February 15, 2017, from https://www.nami.org/About-NAMI/Publications-Reports/Public-Policy-Reports/State-Mental-Health-Legislation-2015/NAMI-StateMentalHealthLegislation2015.pdf

40. Ibid.

41. Wierwille, J. L., Pukay-Martin, N. D., Chard, K. M., & Klump, M. C. (2016). Effectiveness of PTSD telehealth treatment in a VA clinical sample. *Psychological Services, 13* (4), 373.

KANSAS HEALTH INSTITUTE

The Kansas Health Institute delivers credible information and research enabling policy leaders to make informed health policy decisions that enhance their effectiveness as champions for a healthier Kansas. The Kansas Health Institute is a nonprofit, nonpartisan health policy and research organization based in Topeka that was established in 1995 with a multiyear grant from the Kansas Health Foundation.

KANSAS
HEALTH
INSTITUTE

Informing Policy. Improving Health.