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The Effects of Cutting Funding for Community Mental Health Programs

This report examines the possible impact of reducing the provision of, and funding for community mental health services. We report on studies of the effect of community mental health programs on the use of other public services and the effectiveness of mental health treatment. The report also discusses the experience of two states—West Virginia and Maine—that cut back on community mental health services.

In Vermont, the Council of Developmental and Mental Health Services (VCDMHS) is an association of community mental health centers partially funded by the state (www.vtcouncil.org). Sixteen private, non-profit agencies are located throughout the state. These agencies provide a continuum of services including adult, child and family outpatient counseling, substance abuse recovery programs, community rehabilitation and treatment, emergency services, and developmental services. Each community agency has different capacity to offer specific services. Ten of the sixteen member agencies of the VCDMHS offer both Adult Outpatient Mental Health Services and Community Rehabilitation and Treatment. Eight of the agencies also offer intensive, time limited Emergency Services.

Community Mental Health Centers vs. State Hospitals

According to mental health consumer advocate Steven Miccio and College of St. Rose social work Professor Richard T. Pulice, Ph.D., effective mental health care is contingent on the accessibility of comprehensive, integrated services for people experiencing severe behavioral health problems (Pulice & Miccio 2006). This was a guiding principle behind the "Era of deinstitutionalization" of Mental Health (1950-1963), which culminated in changes to mental health funding in order to establish community mental health centers. The goal of community mental health centers is to offer better quality psychiatric services closer to patients' homes and more integrated into daily life than large state run institutions and hospitals.

When funding for community mental health centers is cut, these centers lack the resources to offer the comprehensive care that keeps patients out of hospitals. Patients experiencing a crisis then seek out hospitalization on an emergency basis (Randall-Aldred-Crouch 239). Particular attention must be paid to the frequency and locations of services provided to patients with mental illnesses in order to ensure the most cost-effective and beneficial practices for clients. The services offered at community mental health centers are focused on sustained, locally based psychiatric treatment, keeping patients out of psychiatric hospitals and allowing them to

lead safe, healthy and productive lives within their home communities (Norquist and Hyman 1999).

West Virginia

West Virginia's experience offers an example of the effects of cutting community mental health funding. Mental health service expenditures dropped from $35.2 million in 1986 to $28.7 million in 2002. By 2003 community mental health centers across the state were forced to close; the burden of patients who had previously utilized or would have utilized their services was put on the state's two psychiatric facilities. Those state facilities experienced overcrowding, were unable to treat all the patients in need of psychiatric services and some patients were turned away from treatment (Cox 2003). Elizabeth Randall, Ph.D., professor of social work at the University of West Virginia and West Virginia social worker Mary Alred-Crouch, MSW, both of whom specialize in rural community mental health systems, called the cuts to West Virginia's community mental health centers a "stop-gap solution [that] may make sense economically, it cannot be sustained over a long term, as the cumulative effects of mental fatigue and burn out will ultimately lead to drastic reductions in the quality of care" (Cox 2003).

Maine

In 2006 the state of Maine adopted the Adult Mental Health Services Plan in order to scale back on mental health services provided by the state. More recently in December 2008, the state of Maine prohibited new admissions to Community Integration Services, Assertive Community Treatment, and eliminated three long-term positions and the Interagency Program Coordinator position. The contract for family services was cut, and a hiring freeze was put into effect at the Riverview Psychiatric Center. This center is the only treatment facility fully run by the State of Maine for eleven counties (Jones 2009, p.1-2).

Mental health service providers have since scaled back on their own expenses and services. As a result services have been reduced and eliminated: outreach performed by staff has declined; clients have been discharged to other providers; there has been an increase in clinical caseloads alongside a decrease in clinical consultation and supervision; clients have had to travel longer distances to available services; there has been a lower level of interaction between clients and clinicians; and, wait lists have become longer (Report to the Court In the Matter of Bates v Commissioner, DHHS, Elizabeth Jones 2009, p.2-3).

According to an analysis by Court Monitor, Elizabeth Jones, for *Bates v Commissioner DHHS*[1], since providers have scaled back their services, there has been an increase in unmet class member needs. From Quarter 2 of 2007 to Quarter 4 of 2008 unmet needs for mental health

[1] On May 16, 2008, the Maine Superior Court was briefed on supplemental budget reductions geared towards mental health services. On July 11, 2008, the Court ordered the appointment of a Court Monitor, Elizabeth Jones.

services increased from 422 to 855, housing resources from 427 to 994, and peer, recovery, and support services from 82 to 207. In the same time period total class member unmet needs increased from 2,419 to 5,844 (See Figure 1).

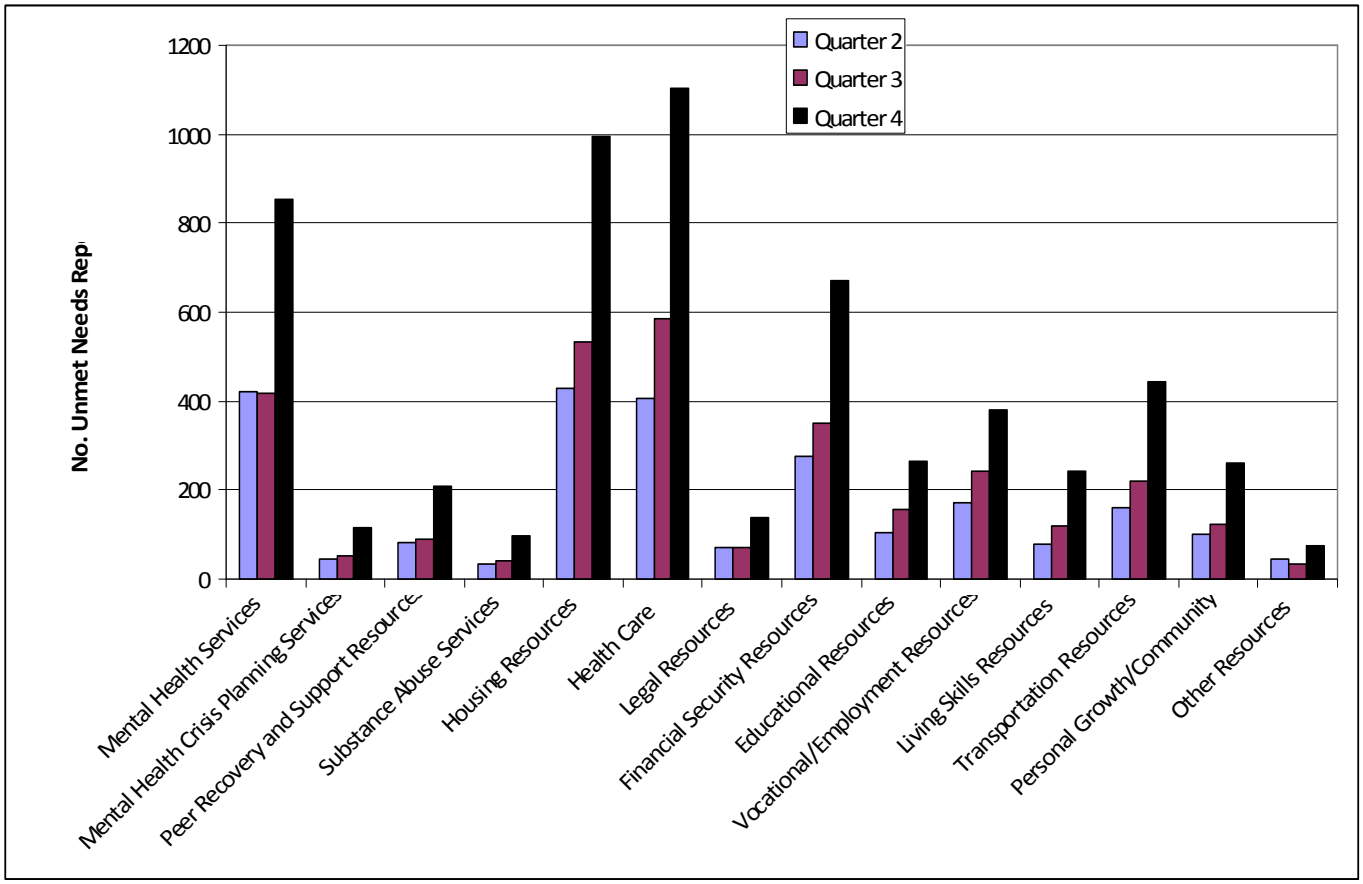

Figure 1: **Unmet Needs and Open Cases for the State of Maine as a Whole Quarter 4 (Apr-June '08), Quarter 3 (Jan-March '08), Quarter 2 (Oct-Dec '07)[2].**
(Source: State Report of Unmet Needs Q4 April-June 2008, p.3)

A report released by Maine Law enforcement officers addressed the cuts in mental health services and their effects on public safety. The report indicated that as a result of mental health cuts by the state there has been an increase in crimes perpetuated by the mentally ill especially in the case of former convicts:

> There is presently a growing challenge to existing inpatient and outpatient resources for treatment of people with mental illness. Public safety crises involving people with mental illness have increased both in frequency and seriousness in their threat to all

[2] As reported by providers in the Individualized Support Plan Resource Data Summary.

> parties involved. While psychiatric beds may exist, hospital admission may be denied based on the presentation of the person with mental illness. Additionally, access to 72-hour Riverview Psychiatric Center beds reserved for correctional facilities is presently too limited. This leads to mentally ill inmates being released from jails without needed assessment or treatment, thereby increasing the probability of dangerous incidents in the community (Report of the Ad Hoc Task Force on the Use of Deadly Force by Law Enforcement Officers Against Individuals Suffering From Mental Illness , December 4, 2008).

The findings of the report are further backed by another report that found that there was an increase in law enforcement contacts with people who have mental illness following policy decisions and the implementation of budget cuts from the state budget. The same report documented a 26% increase in the number of mental health-related calls for service in the First Quarter of the fiscal year 2008. (McLaughlin 2008).

Finland

The Academy of Finland funded a study investigating the correlation between suicide rates and changes within mental health services. A nationwide study of all Finnish adult mental health service units was conducted between September 1, 2004 and March 31, 2005. All twenty mainland Finnish hospital districts were asked to report the forms of mental health services they provide. Data for administrative or structural changes in mental health service provisions for the period 1992-2003 as well as suicide data for 2000-2004 was obtained. The study also noted the use of psychiatric hospital treatment for 2000-2004 from the Finnish hospital register.

The study reports that organizational changes and inpatient treatment were significantly associated with risk of suicide. Outpatient services and community based service structures were associated with decreased risk of suicide. Areas with a ratio of outpatient services to inpatient services favoring outpatient services saw a decrease in suicide mortality.

> Even after simultaneous adjustment for socioeconomic components, the rate of involuntary admissions, and the number of strategic changes using a multivariate model, the ratio of outpatient versus inpatient service units was associated with significantly decreased suicide risk (RR 0·94, 0·90 to 0·98; ARR 1·2, 0·4 to 2·1). (Community mental-health services and suicide rate in Finland: a nationwide small-area analysis, 2009, p. 151)

The report concludes that multifaceted community based services are the best means to develop modern, effective mental health services.

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Disclaimer: This report has been prepared by undergraduate students at the University of Vermont under the supervision of Professor Anthony Gierzynski. The material contained in this report does not reflect the views of the University of Vermont.