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KEY STAKEHOLDER PERCEPTIONS REGARDING BUDGET CUTS IN IDAHO MENTAL HEALTH SERVICES

By

Oluwafemi B. Abimbade

A thesis

submitted in partial fulfillment

of the requirements for the degree of

Master of Public Health in the Department of Health and Nutrition Sciences

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To the Graduate Faculty:

The members of the committee appointed to examine the thesis of OLUWAFEMI B. ABIMBADE find it satisfactory and recommend that it be accepted.

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June 2, 2014

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RE: Your application dated 5/27/2014 regarding study number 4108: Key Stakeholder Perceptions Regarding Budget Cuts in Idaho Mental Health Services

Dear Mr. Abimbade:

I have reviewed your request for expedited approval of the new study listed above. This is to confirm that I have approved your application.

Notify the HSC of any adverse events. Serious, unexpected adverse events must be reported in writing within 10 business days.

Submit progress reports on your project in six months. You should report how many subjects have participated in the project and verify that you are following the methods and procedures outlined in your approved protocol. Then, report to the Human Subjects Committee when your project has been completed. Reporting forms are available on-line.

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Sincerely,

Ralph Baergen, PhD, MPH, CIP
Human Subjects Chair

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Abstract

The public and private mental healthcare systems in Idaho and across the United States have been impacted by the recent cutbacks in state and federal funding as a result of the most recent economic recession. This has contributed to the current crisis evident in some of the statistics that define behavioral/mental health system. The purpose of this study was to understand the perceptions, opinions and experiences of key mental health stakeholders regarding the impacts of budget cut in Idaho mental health services. A qualitative research study was conducted using semi-structured interviews with 17 mental health stakeholders. Analysis yielded findings that clustered around three broad categories: structure of care, barriers to mental health service delivery and perceived impacts of budget cuts and inadequate funding. Inadequate funding of mental health services prior and after the budget cuts has shifted burden of care to emergency rooms, inpatient hospital units and law enforcement.

Chapter I: Introduction

Mental health according to the World Health Organization (WHO) is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community (www.who.org). Going by this definition, it is reasonable to say that mental health remains central and important to the essence of every individual. According to a growing body of evidence, a positive mental health status is associated with improved health outcomes (www.cdc.org) - this further shows the significance of an optimal mental health state in the overall health status of an individual. The 1999 Surgeon General report on mental health estimated that only about 17 percent of U.S adults are considered to be in a state of optimal mental health (Health & Services, 2000). On the other hand, mental illness refers to all diagnosable mental disorders or health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination) associated with distress and/or impaired functioning (www.cdc.org).

Mental illnesses can affect persons of any age, race, religion, or income and contrary to some cultural perceptions, beliefs or myths; mental illnesses are not the result of personal weakness, lack of character or poor upbringing. More importantly mental illnesses are treatable. There are available psychopharmaceuticals and, psychosocial treatment such as cognitive behavioral therapy, interpersonal therapy, peer support groups and other community services can also be components of a treatment plan that assists with recovery. The availability of transportation, diet, exercise, sleep, friends and meaningful paid or volunteer activities contribute to overall health and wellness, including mental illness recovery (www.nami.org). In light of the above, mental health

remains an important public health topic and the significance of a proper functioning mental health system cannot be over emphasized.

Statement of Problem

In recent years, the distressing state of the mental health system in the United States is evident in some of the statistics that define the mental health system such as prevalence, availability of treatment, costs of mental disorders and expenditures from various mental health services. It has been reported that approximately 26.2 percent (1in 4) of adults aged 18 and older in America suffers from a diagnosable mental illness each year (Kessler et al, 2005). Combining the above percentage with the 2004 United States census suggests that approximately 57.7 million Americans experience a mental health disorder each year (NIMH, 2012). More recent results from the 2012 National Survey on Drug Use and Health (NSDUH) showed that an estimated 43.7 million adults aged 18 or older in the United States had any mental illness in the past year which represents 18.6 percent of all adults in the U.S.

Additionally, one in seventeen U.S. adults ages 18 and older lives with a serious mental illness such as schizophrenia, major depression or bipolar disorder; this represents approximately 6 percent of U.S. adult population (NIMH, 2012). Equally important is the 2005 report from the National Comorbidity Survey – Replication (NCS-R) on lifetime prevalence and age-of-onset of DSM-IV mental disorders which indicated that 50 percent of all lifetime cases of mental illness in the United States begin by age 14, 75 percent by age 24 and despite the availability of effective treatments there are still long delays between the first onset of symptoms and when people seek and receive treatment (Kessler

et al, 2005). With the possibility that approximately 50 percent of Americans will meet the criteria for a *DSM-IV* mental disorder sometime in their life, and first onset usually in childhood or adolescence, interventions aimed at prevention or early treatment need to focus on youth.

Burden of Mental illness

The burden of mental disorder shared by children and adolescents is evident in the data from the Center for Disease Control and Prevention (CDC) and NIMH which showed that approximately one in ten children live with a serious mental or emotional disorder, and 13 percent of children ages 8 to 15 has a diagnosable mental disorder each year. The most common disorder among this age group is attention-deficit/hyperactivity disorder (ADHD), which affects 8.5 percent of this population, followed by mood disorders at 3.7 percent, and major depressive disorder specifically at 2.7 percent (NIMH, 2013). Furthermore, the significance of the simultaneous relationship between mental disorders and substance abuse is seen in the data from the Substance Abuse and Mental Health Services Administration (SAMHSA) which showed an estimated 8.9 million adults with co-occurring mental health and substance use disorders (SAMHSA, 2012).

Economic Burden of Mental illness

Not only does mental illness affect the quality of life there are also significant financial costs associated with it. The financial costs associated with mental illness can be divided into direct and indirect costs. Direct costs are associated with direct expenditures from mental health services and treatments while indirect costs are from expenditures and losses related to the disability caused by mental disorders, and also include public

expenditures for disability support and lost earnings among people with serious mental illness (NIMH, 2014). A Center for Disease Control and prevention (CDC) report in 2003 estimated the total costs associated with mental illness to be $300 billion annually; this included approximately $193 billion from lost earnings and wages, and $24 billion in disability benefits in 2002 and $100 billion in health-care expenditures in 2003 (www.cdc.org). It is estimated the annual economic indirect cost of mental illness to be $79 billion and most of which, approximately $63 billion reflects the loss of productivity as a result of mental illnesses (Reports of the Surgeon General, 1999). Apart from the significant economic burden associated with mental disorders, in 2010 the WHO estimated that mental and behavioral disorders account for 13.6 percent of total U.S. disability-adjusted life years (DALYs) – the total number of years lost to illness, disability, or premature death within a given population. This reflects a significant contribution of mental illness to the leading causes of disability in the U.S (NIMH, 2014).

Next, the recent statistics on mental health services utilization and treatment among adults and children in a given year which include all adults and children who received care in inpatient or outpatient settings and/or used prescription medication for mental or emotional problems reported by SAMHSA in 2012 further revealed some of the many problems facing mental health services and treatment in the U.S. According to the report, 60 percent of adults and almost 50 percent of youth ages 8 to 15 with a mental illness received no mental health services in the previous year. Out of the 43.7 million adults aged 18 or older with mental illness in 2012, approximately17.9 million (41.0 percent) received mental health services in the past year. Though there are available effective treatments and services for mental illness, approximately half of the 60 percent

of adults that did not receive any mental health services did not do so because they could not afford the cost (SAMHSA 2012). Out of the 9.6 million adults aged 18 or older with a serious mental illness in 2012, only 6.0 million (62.9 percent) received mental health services in the past year. Thus this has created a system where many individuals with mental illness go untreated and this has definitely contributed to the deadly and costly consequences seen in suicide statistics, unemployment rates and school drop-out rates among mental health consumers.

Suicide and Mental Illness

According to the American Association of Suicidology (AAS), mental disorders are generally associated with a higher rate of suicide; growing research supports the view that more than 90 percent of completed suicides had one or more mental disorders which were often undiagnosed or untreated (AAS, 2010). The above is an indication that there are significant psychiatric illnesses especially mood disorders and substance abuse which increased risk for suicide among adolescents and young adults at the time of death by suicide. Additionally, the 2010 data from the Center for Disease Control and Prevention (CDC) showed that suicide is the 10th leading cause of death among adults and 3rd leading cause of death among young adults aged 15 - 24 in the United States. In that year there were 38,364 deaths by suicides - an average of 1 every 13.7 minutes and 105 each day. From 1999 to 2010, suicide rates continued to increase significantly across the U.S. (CDC, 2014); also the SAMHSA survey in 2012 estimated that the number of suicide attempts increased from 1 million in 2010 to 1.3 million in 2012. A significant impact of suicide is seen in some of the problems encountered by suicide survivors. Suicide survivors are family members or friends of a person who died by suicide and who are left

grieving and struggling to understand (AAS, 2014). They are left with grief that is complex and traumatic; they sometimes get less support from the society or community as a result of stigma, shame and isolation associated with suicide; deal with the police; handle press inquiries; are predisposed to post-traumatic stress disorder (PTSD) and anxiety disorders that can become chronic if not treated (AAS, 2014). The above represents a few of the many effects of suicide on family members and friends of individuals who commit suicide. Besides the impact of suicide on family members and loved ones of individuals who die by suicide, there are significant financial and economic costs of suicide. In 2010 an estimated $34.6 billion in combined medical and work loss costs were due to suicide, and non-fatal injuries due to self-harm or attempted suicide cost an estimated $3 billion annually for medical care. Another $5 billion is spent for indirect costs, such as lost wages and productivity (CDC, 2010). Finally, in terms of Years of Potential Life Lost (YPLL) before age 65 – an important measure of mortality, suicide accounts for approximately 7 percent of all YPLL-65 for all causes of death in 2010 (CDC, 2010).

Mental Illness and School Dropout

Besides the significant contribution of mental illness to the high rates of suicide in the U.S, untreated mental illness has contributed significantly to the school dropout crisis in America (NAMI, 2013). In a report from NAMI, approximately 11 million children and adolescents in America have psychosocial, mental health or developmental problems that contribute to barriers in learning that affect school completion (NAMI, 2014). Children and adolescents with mental disorders fail more courses, earn lower grade point averages and miss more days of school than children with other disabilities which

ultimately increase their risk of dropping out of school (NAMI, 2014). Similarly, the relationship between inadequate treatment of mental illness, tardiness, and absenteeism is seen in a study by Gall, Pagano, Desmond, Perrin, & Murphy in 2000 that showed that referral to a school-based mental health center or counseling reduces absenteeism rates by 50 percent and tardiness rates by 25 percent (Gall et al, 2000).

Equally important is the 2008 report from the U.S government office of Accountability (GAO) on "Young Adults with Serious Mental Illness" that compared rates of high school graduation between young adults with mental illness and those with no mental illness; showed that those with serious mental illness have significantly lower rates of high school graduation (64 versus 83 percent) and continuation into postsecondary education (32 versus 51 percent) (GAO.gov). Also, more than half of the students with a mental health condition ages 14 and older who are served by special education drop out−the highest dropout rate of any disability group and approximately 50 percent of students labeled with emotional or behavior disorders dropped out of school; only 42 percent of those who remained in school graduated with a diploma (NAMI, 2014).

In light of the above, a significant percentage of children and adolescents suffer from mental illness and sadly only a few receive mental health services; according to NAMI, 10 percent of children and adolescents suffer from mental illness severe enough to cause impairments, but approximately 80 percent do not receive needed services in a given year. Untreated mental illness increases the risk of school dropout which more often than not predisposes the affected children and adolescents to negative outcomes such as delinquency, unemployment, poverty, substance abuse and early entrance into the

criminal justice system. The impact of mental illness on the juvenile justice system is evident in the high prevalence of psychiatric disorders in the juvenile system; nationally, an estimated 65 percent of males and 75 percent of females in the juvenile justice system have a least one psychiatric diagnosis with at least 20 percent experiencing significant functional impairment from a serious mental illness, and over 65 percent of the money spent on juvenile justice goes to housing mentally ill youth in juvenile detention facilities (NAMI, 2006). In terms of job opportunities and employment, approximately 60 percent of youth with mental illnesses are employed a year after leaving high school and less than 10 percent move on to post-secondary education . The huge economic cost of lack of education after dropping out of school is evident in the $200 billion lost in earning and unrealized tax revenue for each high school dropout over the course of a lifetime (NAMI, 2013).

Lastly, regarding mental illness and its many appalling statistics, unemployment rates for adults suffering from any mental illness remains significantly high compared to other groups of disabilities. The most recent report from SAMHSA showed that in 2012, adults who were employed part time were more likely than those who were employed full time to have any mental illness in the past year (www.samhsa.org). In addition, the percentage of adults with any mental illness in the past year was higher among unemployed adults (25.5 percent) than among those who were employed either part time (19.8 percent) or full time (15.2 percent) (www.samhsa.org). In 2012, according to the same report, 26.8 percent of adults with a family income below the Federal poverty level in the past year which was the highest for any group of disabilities had mental illness in the past year; and in that same year, 21.9 percent of adults who did not complete high

schools had a mental illness in the past year (www.samhsa.org). Finally, the burden of mental illness on law enforcement is reflected in the percentage of state and local jail prisoners with history of mental health disorder: 24 percent of state prisoners and 21 percent of local jail prisoners have a recent history of a mental health disorder (NAMI, 2006).

Mental Illness Statistics in Idaho

Mental health statistics in Idaho have not being encouraging in the recent years; Idaho continues to be among the states (others are Mississippi, Oklahoma, Utah, Washington and West Virginia) with the highest rates for any mental illness and serious mental illness in the U.S (www.samhsa.org). In the most recent report from the National Survey on Drug Use and Health (NDSUH), approximately 20.58 percent of adults 18 years and older in Idaho have any mental illness (AMI) in the past year; this rate puts Idaho in the top quintile of states with the highest rates of mental illness in the U.S (www.samhsa.org). Idaho's public mental health system is responsible for providing a significant percentage of mental health services in the state but it only provides services for 16 percent of adults who live with serious mental illnesses (www.nami.org). The consequences of untreated mental illness in Idaho is evident in the state being ranked 4th highest in the Nation (67 percent higher than the National average) for completed suicide in 2009; though it may be impossible to determine the cause of every suicide, various researchers have showed that untreated mental illness is a leading culprit (Idaho State Planning Council on Mental Health, 2012).

Though suicide is the 3rd leading cause of death among adolescents and young adults in the U.S., it is the 2nd leading cause of death for Idaho youths ages 14 – 34. Furthermore, the economic burden of suicide in Idaho is evident in the 2010 Idaho Suicide Prevention Hotline Report by the Institute of Rural Health at the Idaho State University as cited by Suicide Prevention Action Network of Idaho (SPAN): "suicide attempts in Idaho result in $36 million in costs annually while Idaho's costs for suicide completions annually is over $850,000 in medical care alone, and $343 million in total lifetime productivity lost" (www.spanidaho.org). Regarding school dropout in Idaho; in the 2006 - 2007 school year approximately 47 percent of Idaho students age 14 and older living with serious mental health conditions who receive special education services dropped out of high school (NAMI, 2010). Finally, the shifting burden of mental illness to law enforcement and criminal justice is reflected in the increasing number of adults with mental illnesses incarcerated in prisons in Idaho; an estimated 1,700 adults with mental illnesses were incarcerated in prisons in Idaho in 2008 (www.nami.org).

Significance of Study

The question is: what has contributed or is responsible for the recent decline in the mental health system? The economic recession that hit the United States in the recent years has significantly impacted the already inadequate mental health system. Consequently, the deteriorating financial conditions in various states across the U.S. have led to reduction in spending for mental health services and programs (Levit, Mark, Coffey, Frankel, Santora, Vandivort-Warren & Malone, 2012). Since the end of the recession in 2009, reduced spending for mental health services in various states across the U.S. resulted in closure of 2,200 psychiatric beds in the state hospitals of twenty-five

states, restrictions on the populations served, and the reduction of state mental health authorities' funding of community services in 75 percent of the states (Levit et al, 2012).

More importantly, the recent NDSUH report stated that only 41.0 percent of the 43.7 million adults aged 18 or older with AMI in 2012 received mental health services in the past year (www.samhsa.org). Though research suggested that even prior to the economic recession more than one-half of people living with serious mental illness received no services in a given year (Kessler, 2005 as cited in Honberg, Diehl, Kimball, Gruttadaro, & Fitzpatrick, 2011). It is very likely that the significant cuts or decreased in spending for mental health services and programs that occurred in a number of states have further diminished access to needed services (www.nami.org). Generally, healthcare funding expands across the private sector (individuals inclusive) and public sector which comprises the state and federal government. Mental health funding, on the other hand, relies significantly on the federal and state government support because of the vulnerable population with mental disorder. According to the National Alliance on Mental Illness report in 2011, the two largest sources of state support for mental health services are Medicaid (46 percent in 2007), a joint federal-state program, and state general funds administered by state mental health authorities, (40 percent in 2007) (Honberg, Diehl, Kimball, Gruttadaro, & Fitzpatrick, 2011).

Enacted in 1965 through amendments to the Social Security Act, Medicaid is a health and long-term care coverage program that is jointly financed by states and the federal government. Each state establishes and administers its own Medicaid program and determines the type, amount, duration, and scope of services covered within broad federal guidelines. Also, states are required to cover certain mandatory benefits and may

choose to provide other optional benefits. Federal law requires states to cover certain mandatory eligibility groups, including qualified parents, children, pregnant women with low income, older adults and people with disabilities with low income (Medicaid.gov, 2012). Consequently, Medicaid provides health coverage to nearly 60 million Americans, including children, pregnant women, parents, seniors and individuals with disabilities (Medicaid.gov, 2012). Though Medicaid remains an extremely important source of funding for people with mental illness, many mentally ill patients do not qualify: either because their income is higher than the Medicaid threshold or because they are too ill to apply and qualify for Medicaid. Therefore, most children and adults with serious mental illness depend on state general funds for their mental health needs (Honberg et al, 2011).

From 2009 to 2011, an estimated total of $1.6 billion dollars was cut back by states in their non-Medicaid state mental health spending - state general funds administered by state mental health authorities (Honberg et al, 2011). To mention a few examples - in New York, programs operated by the Offices of Mental Health, Mental Retardation and Developmental Disabilities, and Alcoholism and Substance Abuse Services were reduced by $151 million and Ohio has discontinued almost all funding to behavioral health services for individuals not eligible for Medicaid (Ackerson, Hack-Ritzo, Koerner, Korr, Larrison, & Schoppelrey, 2011). The enhanced federal funding (a stimulus package to increase federal support) of Medicaid in response to the recession expired in June 2011 and this has led to a significant reduction in federal support to this important program. In response, many states proposed changes that will further erode vital treatment and support for mental illness. The state of Idaho suffered a loss of 11.4 percent of its total general mental health budget from 2009 to 2011(Honberg et al, 2011).

According to the 2011 NAMI reports, Idaho and some other states have reduced the number of people served in both inpatient settings and community services (Honberg et al, 2011). Finally, state budget cuts are forcing community mental health centers nationwide to eliminate programs, ration care and treat some patients only when their conditions reach the crisis-intervention stage (Rosenberg, 2011).

Bracketing and Assumptions

In qualitative research, the researcher is the instrument for analysis across all phases of the study, thus there is some level of subjectivity in what data is collected and way it is analyzed (Tufford & Newman, 2012). The subjective nature of qualitative study entails the "inevitable transmission of assumptions, values, interests, emotions and preconceptions with the and across the study. These preconceptions influence how data is gathered, interpreted, and presented (Tufford & Newman, 2012). However, subjectivity should be limited by using a method called "bracketing". Bracketing refers to an investigator's identification of vested interests, personal experience, cultural factors, assumptions and hunches that could influence how the study is viewed (Fischer, 2009). In an effort to bracket my biases, I have outlined my personal background, interests and goals often referred to as "disclosure," an exposure to view. This will help readers see where I am come from, the perspectives from which the study was designed and the data analyzed (Fischer, 2009). I started my behavioral health journey during my psychiatry rotation as a medical student in 2005; where I saw some of the avoidable problems mentally ill patients go through; observed the unjustified stigma and rejection associated with mental illness. That experience put on my mind the need to pay more attention to the plight of mental health consumers and contribute in any way possible to reduce this

public health concern. Since I started my master of public health degree program in spring of 2012, I have been working with individuals with mental illness and currently as a psychiatric technician at Saint Alphonsus Behavioral Health Unit, Boise Idaho, I have observed some of the impacts of inadequate funding and decline in community services for the persistently mentally ill.

I also repeatedly checked to see if any assumptions from my background had influenced data analysis and representations of findings and put aside those that seemed to restrict my vision.

Purpose of Study

The information obtained from this research will be useful to inform Idahoans, Idaho state legislators, state and federal government on the perceived impact of recent policy changes and budget cuts in mental health services, and to help create more efficient community behavioral health policies that are people centered. This research aims to examine the perceptions of key stakeholders on the impact of budget/Medicaid cuts on both mental health service utilization and engagement with the criminal justice system among those diagnosed with a mental illness and on the availability of community resources. Mental health system/service utilization will address both inpatient and ER utilization. Contact with law enforcement based on suicide attempts, arrests, and county holds will also be explored. In order to identify perceived changes over time, key stakeholders will be asked to compare and contrast changes in utilization and resources that have occurred at two time points, three years before and three years after budget/Medicaid cuts.

Chapter II: Review of Related Literature

Brief History

Many Americans are aware of the most recent and worst recession since the Great Depression which began in December 2007 and ended in June 2009, though many of the statistics that describe the U.S. economy have yet to return to their pre-recession values (Bureau of Labor Statistics, 2012). Far fewer Americans know that presently states across the country are already seeing increased burden on law enforcement, increased suicide rates, increased incarceration of people with mental illness, decrease in services available for mental health consumers (especially those who do not have Medicaid), and increased demand on hospital emergency rooms and psychiatric wards due to the budget cuts in health spending (Honberg et al, 2011). Though federal spending increased during the recession and post-recession, there was across the board decreased growth in states' health spending (Levit, Mark, Coffey, Frankel, Santora, Vandivort-Warren & Malone, 2012).

The increased federal Medicaid funding from 2009 to 2011 eased the burden of health spending on various states temporarily, but the slow recovery of states from the recession further hampered the growth of state and local health spending. Mental health spending was severely affected because mental and substance use treatment programs depend heavily on funds from state mental health (Levit et al, 2012). On the other hand, mental health spending has begun to increase in some states in the last two years, but between 2009 and 2012 state mental health authorities' non-Medicaid spending declined by approximately $1.2 billion –a net loss of 5.2 percent (Levit et al, 2012). These nation-

wide concerns and the abovementioned behavioral health statistics are just a mere glimpse of this national public health issue, as it is also known that economic hardship, military service, loss of home, physical and sexual abuse, and aging are all risk-factors for mental health and substance abuse struggles (National Institute of Mental Health, 2012). The public often focuses on mental illness only when high visibility tragedies of the magnitude of Aurora theater shooting, Virginia Tech or most recently, Newtown, occur. However, less visible tragedies take place every day in our communities—suicides, homelessness, arrests, incarceration, school drop-out and more. These personal tragedies occur because of the failure of the system to provide access to effective mental health services and support systems (Honberg et al, 2011).

Effects of Budget Cut on Mental Health Services

Various organizations such as the Substance Abuse and Mental Health Services Administration (SAMHSA), the National Alliance on Mental Illness (NAMI), the National Institute of Mental Health (NIMH), the Center for Disease Control and Prevention (CDC) have all examined the effects of this current public health concern. The 2011 report by NAMI "State Mental Health Cuts: A National Crisis", described the various changes in state general funding of mental health services and the effects from 2009 to 2011 (Honberg et al, 2011). The report described the different phases of mental health funding cuts and the corresponding impacts. During the early years of the recession, states responded to mental health budget reductions by cutting state office personnel, reducing staff hours and other administrative expenses. As the recession further deepened, budget cuts increasingly focused on elimination or downsizing of programs, services and professional workforce (such as psychiatrists, psychologists and

social workers) as well as on reducing eligibility for services. Lutterman, (2010), as cited in Honberg et al,(2011), described “the specific services that were eliminated or downsized as the most essential services that helped children and adults living with serious mental illness avoid crises and move toward recovery”.

These include:

• Acute (emergency) and long-term hospital treatment

• Crisis intervention teams and crisis stabilization programs

• Targeted, intensive case management services

• Assertive Community Treatment (ACT) programs

• Supportive housing

• Targeted case management and clinic services for children and adolescents

• Access to psychiatric medications

Overall, states have cut vital services such as community and hospital based psychiatric care, housing and access to medications for the majority of youth and adults living with the most serious mental illness. The burden of these cuts still remains with the community, rather than saving states and communities’ money, these cuts simply shifted financial responsibility to emergency rooms, community hospitals, law enforcement agencies, correctional facilities and homeless shelters. Various research studies on the criminal justice system and its interaction with people with any mental illness (AMI) or serious mental illness (SMI) also continually show that the majority of individuals in

correctional facilities have mental health problems or substance use disorders, or both. Additionally, the media which is a very powerful tool for capturing national attention, has reported numerous times on how jails in particular have become the largest institutional setting for people with serious mental illness (www.bazelon.org). Contrary to public opinion and beliefs that associate people with mental illness as being very violent, reliable documented studies have shown that people living with serious mental illness are no more violent than the rest of the population. More often than not these individuals are far more frequently the victims of violence than the perpetrators of violent acts (Honberg et al, 2011).

Mental Health Services in Idaho

In Idaho, the eleventh least populated state in the U.S. with approximately 1.5 million residents, nearly 54,000 adults and 18,000 children live with a serious mental health illness (www.NAMI.org). Worthy of note is the fact that Idaho does not have a good track record of funding services for the persistently mentally ill, and sadly with the deteriorating financial conditions following the most recent recession, Idaho's level of support for mental health services is in a deplorable state. This is evident in some of the statistics that define the mental health system in the state (NAMI Idaho, 2012). Idaho's public mental health system provides services to nearly 20 percent of adults with any serious mental illness, leaving the rest untreated or relying on more expensive settings for psychiatric treatment (www.magicvalley.org). In 2012, Idaho spent just $44 per capita on mental health while the national average is $122 per capita and only four states spent less than Idaho on a per capita basis. (NAMI Idaho, 2012). On a percentage basis, Idaho was in the top ten states (number 8) in the nation making major mental health care budget cuts

between fiscal year 2009 and 2012 (NAMI, 2011). Idaho cut $10.2 million (approximately17.9 percent) from its mental health care budget between fiscal years (FY) 2009 and 2012, and only one state budgeted less than Idaho for mental services in fiscal year 2012, according to a national report issued November 12, 2011 by the National Alliance on Mental Illness.

Idaho's mental health services have been limited to cover only crisis interventions which ultimately lead to increased taxpayer burden by shifting cost to emergency rooms, inpatient hospitalizations, law enforcement, prisons and jails (NAMI Idaho, 2012). Sadly, law enforcement agencies have become first responders or default responders for the mentally ill and local communities have to cope with residents who are negatively affected by state budget cuts. The increased use of these alternative services and their related costs is being experienced throughout the state. Idaho has cut funding to various community supports such as assertive community treatment (ACT), mobile crisis teams, psycho-social rehabilitation (PSR), job training, and housing which focus on recovery and re-integration of those living with mental illness into the community (NAMI Idaho, 2012).

Effects on Hospitalization

Levit et al in 2012 stated that reduced spending in mental health services led to closure of psychiatric beds in twenty-five states' mental hospitals, decreased spending for community mental health services and reduction in population served by over 75 percent of the states (Levit et al, 2012). Hospitalization of patients with psychiatric disorders in terms of readmission, length of hospital stay and frequency of admissions were impacted

due to the closure of psychiatric beds in various states. Ohio, which once had one of the top mental health systems in the country, now subsequent to the budget cuts have thousands of youth and adults living with serious mental illness unable to access care in the community and ending up either on the streets or in far more expensive settings, such as hospitals and jails (Honberg et al, 2011). Another example is seen in Rhode Island which cut mental health funding in 2008 and this led to a 65 percent increase in the number of children living with mental illness rooming in public hospital emergency rooms, with no place to go for treatment (Honberg et al, 2011). In a study carried out in 2008 on Medicaid cutbacks and state psychiatric hospitalization of patients with schizophrenia in Oregon, McFarland and Collins found that the loss of Medicaid coverage seemed to have little impact on involuntary admission to local general hospitals, but there was a strong connection between Medicaid termination and increased state psychiatric hospitalization (Collins & McFarland, 2008). A possible explanation for the above finding is that Medicaid covers local general hospital stay but does not pay for state hospital care, therefore, it reasonable to think that general hospital providers would encourage civil commitment court hearings (the gateway to the state psychiatric hospital) for individuals who lost Medicaid than for those who retained coverage (Collins et al, 2008). Also, patients with Medicaid coverage maintained contact with outpatient mental healthcare providers and are subsequently referred to general hospitals if there are signs of mental deterioration. I Individuals who have lost their Medicaid coverage most likely do not have adequate outpatient services, therefore admission into general hospitals are delayed until patients go into crises or significant decline in mental functions and

ultimately the patients require both general hospital and state psychiatric hospital care (Collins et al, 2008).

Finally, and in line with the NAMI reports, there have been increased visits to emergency rooms, hospitalizations, homelessness, entanglement with juvenile and criminal justice systems, the loss of critical developmental years, premature deaths and suicides as a result of the recent cut backs in mental health spending (Honberg et al, 2011).

Increased Burden on Law Enforcement

Law enforcement and judges have become front-line responders to people in crisis due to the lack of timely mental health services. Not surprisingly, police officers and judges are among the most vocal critics of recent funding cuts in mental health services (Honberg, et al, 2011). In the NAMI reports, Honberg et al, (2011), described a proposed 12.4 percent reduction in mental health budget in Nevada which was supposed to reduce the number of youth and adults receiving out-patient mental health services. Consequently, various law enforcement agencies informed the legislators that rather than save costs, cuts of this magnitude will lead to increased costs. Judge Glass whose county was going to be severely affected stated that paying less would ultimately result in paying more later when people who lose mental health services end up in prison, jails, emergency rooms, homeless, harassing tourists and breaking into homes (Vogel, 2011). Another example of the increased burden on law enforcement is seen in Oklahoma where calls to police involving psychiatric emergencies increased by 50 percent (Honberg et al, 2011). Stacy Puckett, executive director of the Oklahoma Association of Chiefs of Police

stated that as a result of the rise in psychiatric emergency calls, police officers travel from one end of the state to the other and out of their departments, six, eight, and ten hours at a time searching for psychiatric beds for those who need them (Zezima, 2010).

The burden on law enforcement due to pervasive mental illness has not exempted smaller cities such as Pocatello in southeast Idaho. Citing Major Michael Stayner, Deputy Chief of Police, Pocatello Police Department "not providing adequate mental health treatment places additional burdens on law enforcement. Because there will be fewer mental health treatment resources, law enforcement will have fewer options for the mentally ill. This may result in more incarcerations in local jails which are exactly what we, in law enforcement, have been working hard to prevent. This will present a great disservice to the mentally ill and the community as a whole" (Idaho State Planning Council on Mental Health Report, 2010). The burden of mental illness on law enforcement is reflected in the percentage of state and local jail prisoners with history of mental health disorder: 24 percent of state prisoners and 21 percent of local jail prisoners have a recent history of a mental health disorder (NAMI, 2006). Nationally, 70 percent of youth in juvenile justice systems have been diagnosed with at least one mental disorder with at least 20 percent experiencing significant functional impairment from a serious mental illness (NAMI, 2006). In 2008, approximately 1,700 adults with mental illnesses were incarcerated in prisons in Idaho, and also, an estimated 31 percent of female and 14 percent of male jail inmates nationally live with serious mental illness (Sabol, West, & Cooper, 2010).

Conclusion

In the face of budget pressures as a result of the deteriorating financial conditions across the U.S., budgets cuts seem to be inevitable. From the growing body of research and evidence discussed, it is evident that this vulnerable population - the mentally ill, are being severely affected by the financial crisis. Citing the NAMI Idaho president "it does not only makes fiscal sense but it is morally the right thing" when it comes to funding state mental health services; making right policy decisions that will positively impact the mentally ill remains critical in resolving the current mental health crisis (www.NAMI.org).

Chapter III: Method

Research Design

To answer the research questions that were listed in the previous chapter and understand the opinions and perceptions of stakeholders, a qualitative approach and methodology was used to gain the greatest amount of information or data for the study. Qualitative methodology is the best fit for this study because this method seeks to understand a given research problem from the perspectives of the local population it involves (mental health stakeholder in this case). This method is also effective in obtaining people's experiences of health needs, health care, accessing care and keeping healthy ("Qualitative Research Methods Overview", n.d., p.1). Specifically, phenomenological approach was used because this approach explores the meaning of several individuals' lived experiences which I find to be relevant to this study (Tuohy, Cooney, Dowling, Murphy, & Sixsmith, 2013).

Sampling and Participants

To ensure a credible and indicative sample selection where statistical representativeness is not the goal, purposive sampling technique was used. This type of sampling technique group participants or interviewees to preselected criteria relevant to the research questions and is very useful when there is a need to reach a targeted sample where sampling for proportionality is not the main concern. Though Creswell in 1998 recommended a sample size of up to ten interviewees for a phenomenological study (Creswell, 2007 as cited in Leech & Onwuegbuzie, 2008), sample size in this study was determined on the basis of theoretical saturation –the point in data collection where new data no longer bring additional insights to research questions ("Qualitative Research

Methods Overview", n.d., p. 4). Additionally, to identify other potential interviewees, snowball sampling technique (also known as chain referral sampling) - a type of purposive sampling was also used.

In this method, key informants with whom contact was made were able to use their social networks to refer the researcher to mental health stakeholders who participated and contributed to the study. The participants for this study were selected from four of the seven mental health regions in Idaho: region 3, 4, 6 and 7. These regions represent approximately 60 percent of Idaho's population. 40 percent of the total sample was recruited through purposive sampling and 60 percent of the sample via snowball sampling. A convenience sample of 17 mental health stakeholders participated in the study. Three stakeholders that were contacted through referral from other stakeholders decline to participate because they believe the topic was too "political". Table 1 shows the number of stakeholders and their job descriptions.

Table 1: Study Participants

No. of Participants (n)	Stakeholders
2	Psychiatrist
1	Director of Finance and business development
6	Clinicians - Licensed clinical social worker, Emergency room social worker
1	Law Enforcement Officer
2	Chief Executive Officer and Hospital Administrator
1	Senior Mental health Agency Director
2	Non-clinical Managers - Mental health court coordinator and behavioral health administrative director
2	Clinical Managers - Director of Nursing and nursing supervisor

Of the sample, 9 were female; approximately 60 percent had clinical degree (MD, RN, and LCSW) and 50 percent had background in behavioral health policy and financial background. Data was collected from May 2014 to August 2014 under the approval of the Institutional Review Board of the Idaho State University.

Key Informant Interview Procedures

Psychiatric disorders was "defined as those involving a primary *ICD-9* diagnosis in the range of 290 to 319. Psychiatric disorders was aggregated into several categories: schizophrenic disorders, bipolar disorder, other psychotic disorders, major depressive disorder, other depressive disorders, anxiety disorders, dementia, organic disorders other than dementia, substance-related disorders, and all other disorders' (Ettner & Hermann, 1998).

The researcher conducted the interviews at interviewee's place of employment. Some of the participants requested a copy of the interview guide beforehand in order to be well prepared for the main interviews. The interviews were conducted on a one-on-one basis and face to face. Interviews lasted between 45 – 60 minutes except for two of the stakeholders whose interviews lasted for 2 hours; these were the stakeholders that worked in the public mental health system. The researcher introduced the topic and explained the purpose of the study. The participants were given a cover letter which included an informed consent form which all the interviewee's signed before the interviews started.

The semi-structured questions provided the interviewer and interviewee with some format and helped direct responses, with most the interviewee having the opportunity to elaborate when the need arose. Standardized initial questions were able to clarify the following: (1) subjective impressions of current mental health services; (2)

perceptions of mental health professionals and stakeholders regarding mental health services utilization subsequent to the cut backs; (3) availability and access to community resources prior and post budget cuts. The questions in the guide gave more insight on the stakeholders' knowledge of mental health funding – State, Federal, City and County level. Also, assessed the opinions of the stakeholders on available of services, community resources before and after the cuts and recommendations for the political leaders, community and Idahoans. The interview guide also asked additional questions specific to some of the key informants- for example additional questions for the law enforcement professional. The key informant interview guide was based on existing literature on mental health services and mental disorders. As appropriate, additional questions were asked to gain more insight into the issues raised by interviewees. The interview guide can be viewed in the appendix and comprised 12 questions.

Data Management

Interviews were recorded on an mp3-compatible recording device and professionally transcribed. The recordings were listened to in private and kept in a secure place to ensure confidentiality. Transcriptions were compared to the audiotapes to correct errors or omissions.

Data Analysis

To analyze the data from the interviews, a constant comparison approach was used. The goal of constant comparison analysis according to Creswell in 2007 and Merriam in 1998 as cited in Leech et al is to generate a theory, or set of themes. The relevance of this type of approach to the research topic is evident in the main characteristics of constant comparison analysis: (a) to build a theory, not test it; (b) to

give researchers analytic tools for analyzing data; (c) to assist researchers in understanding multiple meanings from the data; (d) to give researchers a systematic process as well as a creative process for analyzing data; and (e) to help researchers identify, create, and see the relationships among parts of the data when constructing a theme (Strauss & Corbin, 1998 as cited in Leech & Onwuegbuzie , 2008).

The data analysis started by transcribing all the data collected from the interviews into a word processing document – Microsoft Word. To get to know and understand the data for good analysis, the researcher read and re-read the transcripts and wrote down any impressions that surfaced from going through the data. Data analysis took place alongside data collection which allowed some questions to be refined and new avenues of inquiry to develop as the interviews continued. An example is, the question asked to understand the opinions of the participants on funding for mental health services in Idaho had to be reviewed and refined.

The next major step in the analysis is coding and developing category systems; according to Strauss and Corbin, there are three stages associated with this step: open coding; axial coding and selective coding. Open coding is marking segments of data with symbols, descriptive words, or category names. During this stage the researcher carefully reads the transcripts line by line and divides the data into meaningful analytical units (Strauss & Corbin, 1998 as cited in Leech et al, 2008). After locating meaningful segments, a descriptor will be attached to each segment. This process of coding will continue until all the data is segmented and initial coding is completed. A master list of all the codes will be kept so as to reapply the codes to new segments of data each time an appropriate segment appears. The researcher used NVivo 10 (QSR International, 2014)

computer software for qualitative data analysis, including thematic and group process analysis.

For the purpose of this research, the researcher used inductive codes – these are codes that the researcher developed by directly examining the data. The researcher analyzed the transcripts line by line and was able to code into inductive nodes or codes. Additionally, initial coding is rarely perfect, recoding of the already coded data "further manages, filters, highlights, and focuses the salient features of the data for generating categories, themes,, and concepts, grasping meaning, and or building a theory" (Saldaña, 2009). The researcher recoded and re-categorize the nodes by reviewing the initial nodes which lead to some rearrangement and reclassification of coded data into new and different categories, eliminated repetition and combined similar codes (combined some of the codes that naturally came together) in order to have more refined categories and codes.

Initially, the researcher was able to identify approximately 40 nodes which after further review were reduced to 20 nodes. Axial coding is the next stage which is the point the researcher groups the codes into similar categories. During this stage the researcher focused on nodes that closely reflected the themes emerging from the data. An outline of emerging relationships among the themes and subthemes was also created. The final stage is called selective coding, which is the "process of integrating and refining the data in order to create a theory out of the data" (Strauss & Corbin, 1998 as cited in Leech et al, 2008). Finally to arrive at the outcome of the analysis -the perceived impacts of budget cuts in Idaho mental health services, the researcher searched for trends, connections, patterns and relationships existing in the emergent broad categories, themes and

subthemes from the coded data. The researcher was able to create several comprehensive broad categories, themes and subthemes that showed the perceptions of mental health stakeholders regarding budget cuts and inadequate funding in Idaho mental health services.

Credibility of Research Findings

In order to establish credibility or trustworthiness (qualitative rigor) of the thematic analysis and findings which is an essential component of the data analysis, the researcher employed member checking and triangulation procedures. Member checking involves feedback and discussion of findings from the analysis with the interviewees and assessing how far they consider them to reflect the issues from their perspectives, also for verification and insight (Brikci, 2007). Similarly, Creswell & Miller in 2000 noted that in member checking, validity procedure shift from the researchers to participants in the study (Creswell & Miller, 2000). The researcher took the data and interpretations back to the stakeholders so they could confirm if the categories and themes make sense, realistic and accurate. The stakeholders also assessed how the interpretations reflect issues from their perspectives.

The researcher then used triangulation as the second tool to check credibility. Triangulation is validity procedure that employs only the researcher's lens or viewpoint (Creswell & Miller, 2000). The researcher used multiple forms of evidence – interviewees, articles, and historical documentations, to give support and confirm the findings.

Chapter IV: Results

Results from interviews with various stakeholders across Idaho's Mental Healthcare system provide significant information on the perceived changes in mental health services utilization as a result of recent budget cut backs and on the historically underfunded state public mental or behavioral health system. Qualitative analysis of the interviews yielded findings that were clustered around the following broad categories: perceived impacts of budget cuts and inadequate funding of public mental health services, barriers and factors responsible for access and availability of mental health services, and structure of care. In this section I reviewed the broad categories, themes and the subthemes identified from the data. In table 1, I provided an overview of the broad categories with the associated themes and subthemes. The findings from this study are supported by various specific quotations for the categories.

Perceived impacts of budget cuts and inadequate mental health funding

This broad category describes the various perceptions of the stakeholders regarding inadequate funding of mental health services in Idaho. This category included four themes in which the stakeholders passionately expressed their opinions regarding spending for mental health services in Idaho prior to the budget cuts and after, and the impacts of inadequate funding. They strongly believe and backed up their perceptions with various examples supporting the historically underfunded mental health system in Idaho. There was a general consensus among the stakeholders that the public mental healthcare system in Idaho has always been grossly underfunded and this was further impacted by the recent budget cuts as a result of the recession. They believe that Idaho has always spent little on mental health or behavioral health and Medicaid cutbacks /

budget cutbacks further complicated this problem. Most of the respondents shared similar views in this category with few contrary opinions between state mental health workers and private sector mental health services providers.

Table 2. Broad categories, Themes and Subthemes

Broad categories	Themes	Subthemes
Perceived impacts of budget cuts and inadequate funding	Historically underfunded public mental health system	
	Public mental healthcare service utilization	
	Shift to more expensive settings	Increased burden on the emergency rooms Inpatient hospitalizations
	Interaction with criminal justice system	
Barriers to mental health service delivery	Political/Societal barriers Healthcare Insurance bureaucracy	Reimbursement rates for mental services
	Commitment to mental healthcare	
Structure of care	Community mental health system	Outpatient Services Medication Access Follow-up/prevention
	Continuum of care	

Historically Underfunded Public Mental Health System

The first theme in this category pertained to the historically underfunded public mental health system. All the respondents believe that Idaho has always spent little when it comes to mental health. They all agreed that spending on public mental healthcare services has always been an issue of concern at the national and state levels with Idaho at the bottom of the list in funding per capita for mental health services for adults, adolescents and children. Echoing a common ground the stakeholders agreed that this is not just a current problem of underfunding, but it has been an ongoing problem and Idaho has a history of underfunding the mental health system. They highlighted that Idaho has always been at the "bottom of the barrel" when it comes to funding for public mental health services and funding has always been historically more of a reduction than increase.

One of the respondents commented,

> You always want to measure how you know there are states that spend a lot of money, but they may have a lot of people, it is the money per capita, but in money per capita we are always a low spending state, we do not spend very much money on mental health. The whole time I have been here, the thirty years I have been here, and even before that, we have always been low on that. Medicaid is a federal program but it is implemented on a state level and states have a right to get waivers to treat more or less things under the mental health part of the Medicaid budget and our state has always chosen to fund the least number of things possible, we always have not made Medicaid available to as many people as, in

> my opinion, we have always underfunded Medicaid by not getting the waivers we should.

Furthermore, some of the respondents described various differences in the way healthcare spending is structured across the various states in the U.S; they explained how funds that count toward healthcare spending may vary across states. But they all came to one conclusion that in any angle you look at the issue of state spending for public mental healthcare services, Idaho has always historically ranked low when it comes to money invested or spent per-capita on mental health. This stakeholder stated,

> For example I think we rank 49th out of 50 states for the adults that meaning 48 other states have more funding per capita per adult for mental health services and then for children adolescents I think we are still probably at the 48th out of 50 states meaning 47 states have more funding for children and adolescents than we do. Now this has not changed too much. In 1994 - 1995 when I did my policy analysis on children's mental health we were at 48th out of 50 states for children's mental health. So it has pretty much stayed the same.

Additionally, the stakeholders suggested that not only mental health services have been historically underfunded, but mental health services and substance abuse treatment which make up an integrated system of behavioral health have always been underfunded. One of the respondents stated,

> We have always underserved the severe and persistently mentally ill and the people with severe substance abuse disorders.

The stakeholders agreed that inadequate funding has ultimately created a system where treatment options and services available to mental health consumers are inadequate. This respondent stated,

> I mean Idaho has always been very poor when it comes to the money they spend on mental health and so we have never done a very good job of treating our folks that are mentally ill. If you think about it, even before the budget cuts, there was not a lot of funding anyway.

Public Mental Healthcare Service Utilization

The second theme in this category describes some of the perceived impacts of budget cuts on public mental health services utilization since the budget cuts. The respondents highlighted various changes they have seen in service utilization, access to services, and availability of services following the budget cuts in 2009. There was obvious consensus that as a result of the budget cutbacks some mental health services and programs have been eliminated and there have been challenges in accessing some of the available ones. They talked about some of the challenges faced by consumers since the cuts and steps taken by the state to address the problems. One of the stakeholders who works in one of the state-owned mental hospitals, perceived that with clients not getting regular services they end up presenting in the midst of a crisis, something that they could have been possibly avoided with regular care. She stated,

> I think from our perspective, there have been some challenges with clients getting services or not getting enough service because of the cutbacks, you know back in 2009-2010 or 2011, however I could not speak directly to what those numbers

> were. Just from our observations here, that is typically what we heard from clients, so you know our job is to, if a client is in crisis because of those reasons, our job is to patch them back together again.

Similarly, the respondents agreed that under the budget cuts, it is the ones in crisis who are receiving care and the system can no longer focus on maintaining stability. There was a general perception that the cuts created a system of service exclusion more than inclusion. One of the respondents believes that budget cuts led to changes in job stability, consistency with fewer mental health professionals working on a full-time basis, thereby, limiting services to only those clients with the most pressing needs. This stakeholder commented,

> One thing that happened in Idaho when we rolled out the privatization of mental health is most agencies took on not paying people like a hourly or a salary they paid them by the billable hours. So it created this economy that you could really only provide to those that would show up for care.

Furthermore, one of the respondents believes that budget cuts have impacted not only the quantity of services available but possibly the quality of services with no funding available to evaluate the effectiveness of available services. This respondent stated, "A lot of mental health programs have been cut back, there have been no new initiative that would increase services and they have a hard time measuring quality of the services."

All the respondents broadly agreed on some of the services that have almost been eliminated or cut back. There was a general consensus that psychosocial rehabilitation (PSR) services and hours [now called Community Based Rehabilitation Services

(CBRS)] and case management services available to mental health consumers have almost been eliminated or greatly reduced. PSR and case management services remain vital components in the management of the persistently mentally ill. PSR services are targeted to individuals who have major psychotic disorders and functional impairments; these services are oriented toward empowerment, recovery and competency for the persistently mentally ill. These services include but not limited to the following: skills training, peer support, vocational rehabilitation and environmental supports; and they are part of the community mental health system that supports and helps patients receive care at the community level which ultimately reduces inpatient hospitalizations and other expensive settings of care. Some of the stakeholders perceived that case management services that help patients with their day to day activities have almost been eliminated. Case management or service coordination programs create an avenue for mental health consumers to achieve wellness and autonomy or self-sufficiency through education, identification of service resources and service facilitation. One of the respondents perceived that not only PSR services have been cut back but clients are forced to choose between PSR and other mental health services. She stated,

> What I understand is there has been some cut to the PSR services that are available for people, it seems that they also have to make a choice, they can either have PSR services, a minimum amount of those a week, against another service, and I cannot exactly remember what it is. PSR services have been greatly limited, case management programs or service coordination programs have almost been eliminated.

One of the stakeholders who works in one of Idaho's regional behavioral health offices and was once a case manager, perceived that case management services and procedures used have been greatly reduce because there was not enough funding to sustain these services. She noted that case managers used to go into the community to provide services but they are now office-based and not meeting clients in their real-world settings. She commented,

> Fundamentally, our services have remained with the exception of probably case management. We still provide case management, but the old model where we had 5 or 6 social workers working in the clinic and they had their case loads and they would go out to homes, because when I first started that was what I did. I was hired to do case management and I had a case load of 20-30 people. My entire job was to go out, meet them where they were, fix whatever problems they had and make sure they remained independent. We do not do that anymore, not at least in that way.

Another important service that was perceived to have been impacted by the budget cuts is day treatment for the persistently mentally ill. Day treatment services promote stability and gradual integration of mental health consumers into the community. They serve as alternative to inpatient care or partial hospitalization, as a transitional care following inpatient or partial hospitalization stay in order to facilitate return to the community or to prevent or minimize the need for a more restrictive level of treatment. These services are individualized treatment services for individuals with psychiatric disorders who cannot function in a normal school, work, or home environment and need additional structured activities of this level of care. These services are tailored toward

development of opportunities for personal growth, commitment to community integration, goal-oriented and individualized supports, and promotion of satisfaction and success in community living. Sadly, this important service is perceived by the stakeholders to be inadequate in Idaho. One of the respondents said that day treatment services had already been undervalued and underfunded prior to the budget cuts but since then they have been devastated to the point where day treatment services have been virtually eliminated. She highlighted,

> They (both the public and private sectors) have cut back on day treatment, and there is hardly any day treatment at all.

Similarly, another stakeholder who believes that budget cuts did not only affect state employees and state services but also private providers stated,

> Well I do know that with respect to some of the budget cuts and even the Medicaid cuts I know that there were some private provider organizations that really just did not feel like they could survive. We had day treatment programs close over the last 10 years. So that has been difficult.

Access to affordable housing for the persistently mentally ill is another invaluable service that the stakeholders believe has been greatly impacted by the budget cuts. The stakeholders expressed their opinions regarding the challenges the persistently mentally ill patients face in the area of supportive housing. They agreed that access to affordable, stable, solid, and safe housing has always been an issue in Idaho even before the most recent recession which hit the housing market. Most of the respondents agreed that before the cuts affordable housing was not easily accessible to mental health consumers, there

were waitlists that were about 6 months to 1 year but subsequently after the cuts some are now 3 – 4 years or greater and sometimes are closed. Interestingly, the respondents who work in the public mental health system were more vocal and passionate about this topic, they believe that Idaho has never really had a funding source for housing mental health consumers and housing continues to be one of the gaps in services for those who suffer from mental illness. One of the respondents highlighted that section 8 housing - a federal program administer by the city or county for very-low income families to obtain decent, safe, and affordable rental housing on the private market has been greatly reduced and waitlist for this housing program is closed at the moment.

She commented,

> Even section 8 housing I could not speak in real detail to what the numbers were but we notice that individuals' access to affordable housing and low income housing was greatly diminished.

Furthermore, the stakeholders believe housing problems become more complicated when an individual has a co-occurring mental disorder and substance abuse disorder. According to some of the stakeholders, patients with co-occurring diagnosis tend not to get the adequate and required services and Idaho has never really had an integrated system of behavioral health that takes care of patients with a co-occurring diagnosis. One of the respondent stated,

> In terms of behavioral health if we are really looking at the entire spectrum and that includes substance abuse services. There are clearly fewer options for

> someone that has substance abuse problems. Housing at best is difficult, but it is worse than it ever used to be.

The final perceived impact in this subcategory pertained to the stakeholders' perceptions of reduction in the number of mental healthcare workforce after the budget cuts. Some of the respondents especially the administrators who work in the public mental health system agreed that following reduction in tax dollars allocated to various state agencies as a result of the recession they had to be creative and worked with whatever funds were available to them. The administrators highlighted that most of their spending was personnel and cutting back on the number of staff was seen as one of the options available to cope with the budget cuts. Interestingly, they also perceived that though state agencies were able to reduce public mental healthcare providers, quality of service was not affected. They believe that state agencies were able to maintain good quality of service by changing the type of patients they serve. Their services became primarily indigent services serving as a safety net while they made sure other patients got services from the private sector. One of the administrators commented,

> Personally, I had to lay off, because of the budget cuts, I was faced with laying off, and I do not remember exactly how many, but I think I had to lay off just about 5 staff. Some of those staff came from children's mental health. The state has certainly cut back on the number of state employees that work in the regional programs, but again, I would not say there is a direct correlation to less people being served. That is my perception.

Similarly, the other administrator stated,

> So when I came into the hospital it was the early part of 2008 which in our system is the fiscal year of 2009. So we did have a reduction here at the hospital we had a reduction in the number of staff here at the hospital. We were all asked, the state agencies, to come up with a certain percent reduction to our overall budget. At the hospital the majority of our budget is personnel.

Additionally, the public mental health providers argued that though there was reduction in the number of public mental healthcare providers, more patients got served in the private sectors because the state got creative about case load by helping people with Medicaid, Medicare and other insurance get connected with private providers. According to them, the state ensured that people were getting services, but not with public program while the state focused on being the safety net and primarily indigent services provider. One of them stated,

> But as we cut our state employees, consumers went out to the private sector. So it would be hard for me to say that less people got served, because the hope would be, more people got served; I mean that was the goal. We do not have the state employees to cover the land mass and the amount of people that we help, so let us bring a partner in who is our community partner and let them help us service this group of people.

Also, some of the respondents perceived that reduction in staff number was not only a problem observed in the public system, but private agencies were struggling with keeping adequate number of staff to provide some of the essential services that helped integrate the persistently mentally ill into their communities. They believed that this has ultimately created system of fragmented services where some of the vulnerable

individuals slip through the cracks and has contributed to some of the challenges the mental healthcare system in Idaho faces in order to function as an integrated system focused on continuum of care. This respondent stated,

> I think probably many private agencies had a hard time keeping people employed during that time and so they did not have as many case managers or PSR workers available. I think that many people maybe fell through the cracks.

Shift To More Expensive Settings

The third theme in this broad category describes the unnecessary shift in the care of the persistently mentally ill to more expensive settings such as the emergency rooms (ER), inpatient hospital units and jails. Respondents believe that following budget and Medicaid cutbacks, individuals with severe mental illnesses frequently end up in the general hospital emergency rooms, criminal justice system and inpatient units because funding for community mental healthcare has not kept up with the level of demand and the inability of the community to sustain these vulnerable individuals in the community with proper access to mental healthcare. They all agreed that this has significantly increased burden on the emergency rooms especially and thus the ER has become a de facto mental health clinic. Both public mental health and private providers echoed that the ERs have seen an influx of people with mental health issues. The respondents believe that ERs and the criminal justice system now serve as a safety net for mental health consumers with urgent and immediate mental health needs. One of the respondents said that in addition to inadequate funding, there is an increasing population of patients needing services though the public mental health system. She perceived that as a result of

the economic recession, many individuals were laid off and lost their private insurance and this has indirectly put more demands on the public system. She was of the opinion that people that you do not see needing services through the public system but because the economic recession affected all aspects of the U.S. economy; housing market crashed, job loss just to mention a few led to increase in rate of depression, substance abuse problems and without private insurance or delay in accessing services through Medicaid people end up needing treatment for their psychiatric problems through the public mental health system. She commented,

> I think the pressure for government, the population of people needing services is getting bigger, the amount of money available to serve them is getting smaller, so the demand on that money is getting more and more so they are rationing, if you will, and the people who can function with the rationed amount of services they do okay, but the ones who cannot, they wind up either committing suicide, going to jail, or getting in a hospital.

Some of the respondents perceived that the unnecessary shift to the ERs is as a result of the budget cuts not being targeted to areas where it would have least impact on programs and services and what patients need, thus resulted in many mental health consumers getting into crisis and acting out in the community. This respondent stated,

> I know a lot of the services have been cut or reduced. And I do not think that is necessarily a good thing because I think that drives people, as I said earlier, to the emergency room. They wait until a crisis is upon them and then they hit the highest level of care.

Another important reason highlighted by the stakeholders is the decrease in the number of services covered by Medicaid and challenges with accessing the available ones. They believe that Idaho's decision not to expand Medicaid has negatively impacted services available to patient through Medicaid. Medicaid remains the main source of funding for public mental health services and its privatization and lack of expansion has drastically affected the way services are covered through Medicaid. Thus when sick patients that do not get appropriate services they eventually end up in crisis and get picked up by the police or the ones who understand the system know the best way to get treatment is to do whatever it takes to get them into these expensive care settings and these are the type of situations that the stakeholders have observed. One of the respondents stated,

> The other thing that has happened over the last 5 or 6 years is that Medicaid has continued not to cover services and it is harder to access some services. So what happens is that people access services at the higher ends of care, which are emergency rooms, crisis centers, and urgent care and hospitals. And of course visits to high end care, like emergency rooms, go up, visits to clinics that do psychiatric services, go down because people cannot pay out of their pocket.

The respondents that work at the ERs voiced their opinions on how the cutbacks have shifted the burden more to the ERs and law enforcement. They agreed that the mental health consumers know how the system works and they use this to their advantage, they know that the ERs and police do not turn people away, so when these consumers need to get medication stabilization or are short on resources to keep them in the community they

find their way to the ERs by any means necessary or get picked up by the police. One the ER social worker stated,

> I think as the state has withdrawn their involvement more of it has fallen on the ER and law enforcement. Law enforcement is the second end of the line the ER is the final end of the line. So the police can go out and see somebody and they can always bring them here to the ER, we do not have any place else we can ship them to like the police do.

The respondents who work in some off the inpatient units believe that since the budget cuts they have seen an increase in inpatient admissions, frequency of readmissions and longer hospital stay. Some of the respondents highlighted that they have noticed longer hospital stays for the persistently mentally ill because they feel safe and supported on the inpatient units and prefer this type of care rather than face the uncertainties and challenges when they need services in the community. They agreed that inadequate outpatient and community services have shifted patient care to this units. They all perceived that the shift toward inpatient hospitalizations did not decrease cost because various research have suggested that hospital stays are more expensive than outpatient services or community services. One of the respondents commented,

> So you have longer inpatient stays, which are far more expensive than outpatient services, you have more state hospital stays and longer state hospital stays again which are far more costly than outpatient services.

Similarly, one of the respondents who is also a psychiatric nurse manager, commented that recently at her facility, one of the psychiatrists did a review on how much money the state spent on hospitalizations at the state hospitals. She stated,

> I was absolutely shocked at the amount of money that is spent at state hospitalizations. So, it is cheaper to treat people in residential settings, long-term residential settings, than it is to send them to a state hospital for 6-8 months. Hospitalizations are very expensive and the problem is, I think the color of that money, in other words, the budgets, it looks really good when you are not having all of these programs, but then it looks really bad when you look at how much money they have had to shell out for hospitalizations.

Shift To Criminal Justice System / Interaction With The Criminal Justice System

This final theme in this category pertained to the stakeholders' perception of the unnecessary shift to the criminal justice system where mental health needs are likely to go unrecognized or inadequately treated. There was a general consensus among the stakeholders on the increasing frequency of interactions between law enforcement officers and mentally ill patients in the recent years. They shared their perceptions on the various challenges some of the sickest patients face when they cannot access services, when they get off their medications and end up acting out in the community. When they are in crisis, the law enforcement officers are the frontline responders attending to these patients in crisis. They agreed that crisis intervention has been one of the major calls to the police in the recent years.

Some of the respondents also highlighted the vicious circle mental health consumers go through when they become unstable and start acting out in the community. When they get into crisis, the police are called and more often than not they are placed on a police hold or mental hold and taken to the ER. Police hold or involuntary psychiatric hold is when a qualified law enforcement officer confine a person suspected to have a mental disorder that makes him or her a danger to self, others, and or gravely disabled. This is then followed by admissions into an inpatient unit, they are shackled when they go to court, and ultimately end up spending thousands of tax payer dollars without significant changes in their conditions. A law enforcement officer among the respondents stated, "I can tell you that welfare checks, mental holds, suicidal calls, is our number one call for service if you lump all those together, more than any other activity that police officers do."

Some of the respondents also suggested that the police are doing a great job but without proper training in mental health issues some of the patients in crisis end up in jails. The respondents also highlighted and lauded various steps taken by the state to train law enforcement officers about mental health issues, and mental health crisis intervention. A very passionate respondent that works on both the private and state sector fronts commented on the involvement of law enforcement officers,

> I am also the VP for Boise NAMI the national alliance on mental illness, and you know they advocate for family education, and consumer education and support and research and prevention and even things like crisis intervention teams that help law enforcement interact with people with mental illness at a more

sophisticated level. It is as simple as knowing when someone needs to go to jail or when someone needs to go to the hospital.

Contrary to most of the other respondents, the public mental health providers associated this shift to the inadequacies of the private mental health sector to significantly reach out to the consumers that could not access the public system. A respondent who works with the state stated, “So we still have those that fall through cracks not being outreached to by this private sector, so they end up in ERs, jails and hospitals.”

Finally, regarding the criminal justice system and mentally ill patients. Most of the respondents denounced the perception that mentally ill patients commit a lot of crimes. They talked about the possibilities of patient acting out when they are off their medications and various situations that can result from this. One of the respondents believe that not all criminal activities are produced by those with a mental illness, because many people in today’s society have begun labeling those who do delinquent activities as having mental illness. She emphasized that in courts, defense attorneys are beginning to claim "temporary insanity" and indirectly mental illness has become a norm and topic that is used to blame several negative behaviors when it is just the opposite and is an issue that needs to be properly addressed. This stakeholder commented,

> I think that there is a general public perception that a lot of people with mental illness commit a lot of crime and I think that that is entirely wrong. There is a lot of misinformation about that, I do not know that any more people are committing crimes than they used to, who have a mental illness, I think they are less able to get service than they used to be, but I am not sure that they are becoming more

> criminal. I really think that a lot of perception about that for the majority of the public is really skewed. Based on what they are hearing in the press, but I think the coverage is not really talking about the 70 or however many percent of people that live very well with a bipolar disorder and who are not committing crimes. I think that those statistics are very slanted!

Barriers to Mental Health Service Delivery

In the interviews, the stakeholders validated the broad category of barriers to mental healthcare service delivery. I found that political, community/societal and regulatory barriers to mental health service delivery and commitment to mental health services were saturated themes across most of the interviews with the stakeholders. I will discuss these themes in detail below.

Political / Societal barrier

There was a general consensus that there is no strong political will among Idaho legislators and other elected officials to advocate for a change in the way the mental healthcare system is structured in Idaho. The stakeholders associated this to the conservative nature and beliefs of Idahoans, where a small state government is preferred to a big state government and there is no real commitment to expand the state government. They agreed that Idaho has to balance the state budget every year and mental health spending falls into the discretionary spending category that is often reduced in order to make various adjustments to balance the budget. Also, they agreed that mental health advocacy is not a popular topic among politicians in Idaho. Idaho is perceived as a very conservative state and getting the political leaders to spend money on social services

programs the way it is happening in some other states has not been favorable. One of the respondents who is a state employee emphasized the conservative nature in her comment,

> I mean the private sector is our partner that has helped expand how many people we can serve. A state system alone cannot do that. Especially when you are in a state where it is important for the citizens of Idaho that the state government does not expand, we have conservative beliefs that smaller government is better and personal choice is better rather than just having one system of care.

Also, some of the stakeholders believe that another pointer to lack of political will and commitment to mental health services is evident in the recent privatization of Medicaid and refusal of the last legislative session to expand Medicaid. The respondents believe that some of the steps taking by the legislature and the state government in the recent months have significantly contributed to the current crisis state of the mental healthcare system. It was perceived that privatization of mental health in Idaho created an economy that agencies could only provide services to those that would show up because most agencies started paying their staff by the billable hours. This stakeholder stated,

> I was very saddened that we did not choose to expand Medicaid. This last legislative session, right. Because the one way we can help keep people better and give them treatment is to give them access to healthcare insurance. I think it is the government's obligation to care for people who cannot care for themselves. As a public administrator I think that privatizing most services is a horrible idea, privatized corrections and prisons are an abomination. Privatizing Medicaid, is ridiculous, building a profit mode into something that by nature is not going to

> generate a profit is problematic. Mental healthcare, physical healthcare, substance abuse treatment, transportation, garbage collection, you name it, I think that, I actually think that the role of government should be larger than it is. I am clearly the minority in Idaho.

Commitment to Mental Health Services

There was consensus among the stakeholders that Idaho lacks strong commitment toward mental illness. They believe that all over Idaho mental health issues have not gotten the adequate attention that other medical or physical illnesses have. They agreed that this is a general problem that involves the community, the citizens, all arms of government and elected officials. Lack of commitment is perceived as one of the major problems that has contributed to the challenges faced by mental health consumers in Idaho. This has indirectly contributed to the evident inadequate spending, inadequate community resources and services available to the persistently mentally ill. Some of the stakeholders believe that Idahoans agree there are problems in the mental health system but fixing it is too complicated and expensive. Evidently, mental health funding in Idaho is considered almost optional or an accessory, and Idahoans seemed not to value psychiatric services as some states do. One of the respondents noted,

> Everybody is trying to push the problem to somebody else. Everybody agrees there is a problem, everybody agrees there is not enough services, but nobody wants to pay for it. Someone who has a chronic medical issue, you know maybe they have COPD, maybe they have emphysema or diabetes, or maybe they were born with a chronic health condition, we do not limit funding for those

> individuals. There is Medicaid for people who are disabled, and yet when it comes to mental health, it does seem like pulling teeth to get assistance for those people.

Health Insurance Bureaucracy

The final theme in this category pertained to the stakeholders' perception of insurance companies' involvement in creating additional barriers to psychiatric services delivery. The stakeholders believe that insurance companies' bureaucracy created some of the barriers and challenges mental health consumers face when accessing the available mental health services. Most of the insurance companies developed stringent rules and policies as a result of budget crisis which ultimately affected this vulnerable population that more often than not are helpless. Some of these policies were targeted toward crisis intervention; which allows for payment for services only when patients are very sick or in crisis, medication stabilization and reduction in length of stay. They moved away from some of the other beneficial services that help sustain patients in the community after discharge. This stakeholder noted,

> At one point when insurance companies, I am just going to say insurance companies in general, Medicare, Medicaid and the private insurances, the focus of treatment was to have a client with us for two or three weeks and for the same issue nowadays that same length of stay could be 2 or 3 days. It is more of a brief therapy, more of stabilization. Back then clients would come in, they get stabilized on medications, do some therapy such as family therapy, group therapy; a lot of focus on therapy. Now it is more medication stabilization, and reducing

> the risk factors for suicidal or homicidal behavior and as soon as the person no longer feels suicidal or homicidal, we no longer necessarily go to the intense family therapy or long-term therapy

Reimbursement Rates for Psychiatric Services

Since the budget cuts most of the stakeholders in the private sector perceived that there have been reductions in the reimbursement rates for psychiatric services and this has negatively impacted availability of services and providers willingness to work with some insurance companies. Since Medicaid cutbacks in 2009 many "for profit" facilities have been cautious with type of Medicaid services they provide. One of the stakeholders perceived that this has created a system where facilities think twice before they expand services for Medicaid patients and sometimes lead to facilities reducing the number of beds they have available for certain a population that includes a high Medicaid group. This stakeholder who works at the business end of psychiatric services delivery stated,

> Just to give you an example, I have worked at Intermountain (a private psychiatric inpatient unit in Boise, Idaho) for 11 years and at that time the rate we receive from Medicaid funded patients has gone down slightly. So you think about how facilities or organizations trying to make ends meet, when the price of everything else is going up and reimbursement is either staying the same or going down, it is certainly not encouraging to stay in the Medicaid business.

Some of the respondents believe that not only were reimbursement rates for Medicaid services reduced, some private insurance companies were also impacted by the

recessions leading to cutbacks in their reimbursement rates. One of the stakeholders commented,

> Also we are noticing the reimbursement for insurance companies, which is kind of on the side, Medicare, Medicaid and the rest have decreased and that perhaps have caused a strain in some operating systems and dynamics, I mean the hospital has a budget and it is a for profit hospital, and they are getting reimbursed less, it is going to affect the bottom line.

The reduction in reimbursement rates created a system where some private psychiatric facilities cut back on some services and patients were discharged when they are not fully stable. Patients sometimes get discharged early as a result of pressure from Medicaid and insurance companies asking hospitals to keep costs aligned. Similarly, low reimbursement rates have not been encouraging for some licensed professionals especially psychiatrists to join the Medicaid business which most of the persistently mentally ill patients fall into. This is evident in one the respondent's comments,

> I think one of the biggest places I see cuts and limited funding is the reimbursement rate is so low for professionals that it is very difficult to attract professionals, particularly medication prescribers who are able financially to treat the Medicaid or the uninsured or underfunded population, so a lot of the really mentally ill people with chronic serious mental illness are being treated by nurse practitioners who are well intended, do not get me wrong, but their cases are really complicated and they really deserve to be treated by a physician, psychiatrist. That is one of the biggest places I see the cuts and lack of spending.

Structure of Care

Another significant saturated category among the stakeholders is the way the mental healthcare system is structured in Idaho. This category is centered on two major themes: continuum of care and the community mental health system. Most of the stakeholders described continuum of care as a concept of healthcare that involves an integrated system of care that tracks and guides patients over time through a comprehensive array of health services spanning all levels of intensity of care. They agreed that this efficient system of care is not in place or lacking for the most part in Idaho. They highlighted that in order to have this integrated system of care, Idaho would need to develop a strong community mental health system. A system where there is increased focus on follow-up, prevention and adequate outpatient services.

They agreed that Idaho communities lack the various resources, services and support that should sustain the persistently mentally ill in the community and keep them out of in-patient units. Various services and program that make up the community mental health system include the following but not all-encompassing: outpatient services, access to medication, prevention and follow-up services, mobile crisis response, residential treatment, case management, and supportive housing. Most of the respondents believe that a strong community mental health system with the inclusion of substance abuse treatment for this vulnerable population will improve mental health outcomes, better resource utilization and ultimately burden from in-patient hospitalizations and other expensive settings such as the emergency rooms and jail.

Community Mental Health System

The stakeholders described some of the negative impacts that resulted from patients not having access to proper community care that would help them live in the community and reduce the frequency of hospitalizations. The respondents perceived that when patients do not get services or receive inappropriate level of services in the communities which are less expensive and stand the chance of having better level of outcome, they access more expensive settings such as the emergency rooms or the inpatient hospitals. This has put more burden on ERs and prolonged inpatient hospital stays. One of the stakeholders who works as a social worker at the emergency room commented,

> Anecdotally we have seen well I could even support it with numbers, we have seen a tremendous increase our numbers here in the emergency room for psychiatric patients, which I believe is due, at least in part, to the decline of the community mental health system. People do not know where to go to, they do not have good access, the community services do not go 24 hours a day so they end up here, they do not know where else to go. They are out of medications, they need to establish treatment, and we are providing that service in the ER which is not an emergency service

Also, a veteran social worker at one of the emergency rooms reiterated,

> The emergency room is now being utilized as a community mental health clinic.

The argument here remains that more often than not mentally ill patients that need urgent care, medication stabilization and those in crisis, in the recent years have no other

place to turn to except the ER for their mental needs because the resources and services are not in the communities for them. Concerning the increase in the number of mentally ill patient frequenting the ER, some of the stakeholders affiliated with the state mental health system believe that this is as a result of increased awareness of mental disorders and population growth. But, according to one of the ER psychiatrists who has been monitoring the number of involuntary holds as a result of mental illness in the last 5 years pointed out, the significance of population growth remains a culprit in this recent development but attributed the increase mainly to lack of adequate community services and resources. This stakeholder stated,

> ERs are probably, well one ER in particular at one of the big general hospital ERs we kept track of the ER involuntary holds [people who ended up on involuntary holds]. The first year of the budget cuts they went up from something like 24 average per month to 48. By two years after the budget cuts they went up to 84 which is again about 4 times as much, and most recently they are already up over 120 all the time. So they are up 5, 6 times what they were a few years ago. Now that is not all because of the budget cuts, or because there has been some population growth, but not that much, not enough to explain that. So, really it is lack of services, outpatient access to medications and services have caused and contributed to that.

Another downside of the decline in the community healthcare system is the increase in recidivism among the persistently mentally ill. Some patients cycle from one in-patient unit to another because they do not seem to get adequate services and support in the community. This has led to an increase in in-patient hospitalizations – which is

believed to be more expensive and has increased the frequency of readmissions among these patients. They unanimously attributed the increased frequency of hospitalizations (in an era of advocacy for deinstitutionalization) and repeat admissions to lack of available services and supports in the community. One of the stakeholders stated,

> You can get people stable in the hospital, but you send them out, if they cannot access outpatient medicines, outpatient treatment, outpatient care, what happens, they go off their medicines they get in trouble, they end up back in the hospital, so readmissions go up. And of course we see that all of the time. We are finding more people cycling through the hospital, they are out for a few months, they cannot cope, they come back to the hospital then they are treated released and they kind of sort of cycle in and out. These are chronic mentally ill patients, so if you do not have supports for them then that cycle gets tighter.

Continuum of Care

Finally in this broad category, another saturated theme across all the interviews is the continuum of care for the mentally ill. The stakeholders agreed that Idaho lacks an integrated system that tracks, follow-up and prevents patients from falling through the cracks. There was a general consensus among the stakeholders that they see more of a fragmented system that does not fully integrate prevention, outpatient, supportive housing, and follow-up services. One of the respondents believed that this is not just a problem in Idaho but it seems to be a national issue when it comes to mental healthcare. She believes that nationally there is a need to have a better tracking system for the

mentally ill, better follow up system and commitment from the federal level for an integrated mental health system. This stakeholder stated,

> So the problem is we still do not have the system of care that takes care of you through the spectrum of all the illnesses. As a nation we do not have that. I am not just saying Idaho, in the nation we do not have that down, you know we just do not have the science of mental illness down well enough to have that handle on all of that.

Speaking specifically about Idaho, one of the respondents stated,

> Idaho lacks a continuum of care, you can get some help if you are really ill, but we do not do enough of the preventive work for people. I think that is key, the continuity, whatever is provided we need the continuity of care and the after care and we want to prevent the patient from getting really sick.

Another focal talking point for most of the respondents is the misplaced priority in the area of outpatient services for the persistently mentally ill. Many of them believe that Idaho has a system that would rather spend money on managing a patient in crisis than develop an efficient and less expensive system that integrates outpatient care, prevention and follow-up services. One of the stakeholders believes that in Idaho, mentally ill patients are seen when they become very sick because most of them do not get diagnosed early and necessary processes are not put in place to help them comply with medications, identify and address the challenges they face in accessing proper care. This stakeholder stated,

> It seems like we do spend a lot of money on crisis and emergency care in mental health, we do not spend a lot on prevention, and we do not spend a lot on even people who are first diagnosed, providing them with lots of service so 20 years down the road they are not a hot mess.

In the same vein, one of the respondent who is a law enforcement officer and very familiar with mentally ill patients and their interactions with the criminal justice system commented,

> Well I think there is lack of services to follow up with people that have been put on holds, you get them over their crisis and then there is not enough services to follow up, you know to make sure they are seeing a provider, that they are on the right medication, that people out there are actually seeing them and then also, I think that with the change in the economy since 2008, I know a lot of the mental holds we are dealing with are not repeats they are new people that are in crisis that we did not see before the economy tanked.

Most of the stakeholders also highlighted various negative impacts resulting from lack of a strong follow-up system. One of them described in detail the perceived negative impacts of lack of follow-up and inadequate funding to prevent patient from falling through cracks,

> So they get them on their medications, they are stable, they go to clinicians for two or three months, they are stable and then nobody follows up with them. Well then a year later they feel like the pills are making them sick, the pills are keeping them from sleeping, they are gaining weight, they do not have any sex drive or

> whatever, so they get off their pills, now when they are off their pills, when they first get off their pills they do not notice any difference, two months later, something triggers an event and then they do not have the medication anymore, and then they start hallucinating, and they get in trouble, and they shoot somebody or they get into a fight, or whatever, and next thing you know, then everything goes, then their whole mental thing falls apart, they lose everything, then they get to court and without somebody staying with these guys a lot of the people who have committed some of these mass killings have entered the mental health system at one time or another and there is no follow up. Usually they do not follow up and the system relies on voluntary follow up by the patient, so if the patients do not follow up there is not the resources to send people out and track them.

Finally, some of the stakeholders suggested the benefits of having a system in Idaho that integrates follow-up, prevention, and outpatient services. One of the respondents stated,

> I think that if people got into treatment earlier, and there were more resources, and outpatient providers, and I think if people that have more access to Medicaid presumably they would be treated before they get into crisis mode. To recognize we do not have to wait until there is a crisis or a school shooting or a movie theater shooting we do not have to wait until it is a crisis to treat it, and those things truly are preventable. Although I am not going to say preventable, but we can decrease and try to catch things before they get that bad, I mean we can try.

Chapter V: Discussion -Applying the Findings

Findings from this research add to our knowledge of the various ways in which the public mental healthcare system is affected by inadequate funding. This research clarified how mental health stakeholders in Idaho perceive the impacts of a distressed publicly funded mental healthcare system. Given the dearth of studies addressing the crisis in the mental health system in Idaho, this study adds in important ways to the growing body of literature. In many instances, results from this study mirrors those of other investigators (Honberg, et al, 2011), and suggests that even before the most recent recession, public mental health systems for youth and adults have been inadequately funded across the U.S. Although there is limited literature on funding for mental health services in Idaho, it is important to note that various reports have identified that Idaho does not have a good track record of spending for the persistently mentally ill; in 2006 Idaho spent about a third of the national average, per capita amount on mental health (www.nami.org). It is also important to identify that the stakeholders noticed further cuts to the already underfunded public mental health system in Idaho since the most recent recession. Honberg et al in 2011 reported similar findings in their report on "State of mental health cuts", where they highlighted that Idaho state mental health expenditures decreased by 11.4 percent between FY2009 – FY2011.

Given the stakeholders' perceptions of elimination/reduction of services and challenges encountered by mental health consumers when accessing the available ones, this study provided insight into access and utilization issues among the persistently mentally ill since the most recent budget cuts. For some of the stakeholders, access to services prior to budget cuts was either limited or inadequate, this was also identified by

other investigators (Kessler et al., 2005), that suggests that even prior to the most recent economic recession mental health consumers across the U.S. did not receive treatment. The stakeholders highlighted various services that have been eliminated or downsized and are believed to be very essential and helpful for the persistently mentally ill. Some of these include PSR/CBSR, day treatment services, safe and affordable housing, community mental and substance abuse services and outpatient services. These findings are consistent with that of Honberg et al in 2011 and the Idaho State Planning Council on Mental Health 2012 "Gaps and Needs Analysis" report for the Regional Mental Health Boards that showed limited access to voluntary mental health services, limited access to housing opportunities for people living with severe mental health issues, and limited access to mental health and substance abuse services in the communities. Ultimately, limited access to services created a system where less people were served in both private and the public mental health system. Similar to previous research (Honberg, et al, 2011; Wakefield, 2012), the stakeholders in the private sector perceived that Idaho was among the states that reported reductions in numbers of people served in both inpatient settings and community services between 2007 and 2009. Honberg et al showed in their report that the State Mental Health Authority (SMHA) in Idaho reported approximately 55 percent decrease in the number of people it served in 2009 (Honberg et al, 2011).

However, similar to findings in the 2011 Idaho Board of Health and Welfare report submitted to the Idaho Legislature, stakeholders that work in the public mental health system highlighted that less people got served by the public mental healthcare system because the Division of Behavioral Health in response to the budget reductions refocused its effort to serve only individuals that do not have other benefits such as

Medicaid, while it also ensured that more people got served in the private sector. This created a system where the public mental health system was focused on being the safety net and services were provided to indigent population and individuals in crisis. In light of the difference of opinions on the number of individuals getting services or not, there is a need to design studies that explore and give more insights into this particular topic in order to better serve this vulnerable population.

Shift to More Expensive Setting

Findings from this study suggest that the respondents believe that persistently mentally ill individuals frequently end up in more expensive settings such as the ERs, criminal justice system and inpatient hospital units (Frueh et al., 2012). As mental health services become increasingly difficult to access, and both private and public mental health agencies found it difficult to maintain adequate number of mental health professionals (Appelbaum, 2003); law enforcement, judges, ER physicians became front-line responders to severely mentally ill individuals acting out in the communities or in crisis. This significant shift toward the criminal justice system was a general consensus among the respondents and this has put a huge burden on law enforcement with increased risk to law enforcement officers and excessive demands on public funding at the state, county and city levels (Honberg et al, 2011). Furthermore, there was significant consensus among the stakeholders on the shift toward ERs, though the emergency department physician and social workers among the respondents were more vocal on this topic. The stakeholders believe that the decline in community-based psychiatric services has forced many individuals with mental illness to seek services any way they can or wait until their illnesses worsen and get into crisis before they seek care (Frueh et al., 2012).

This has created a system where over utilization of ERs by individuals in mental health crisis occurs, and has negatively impacted hospital resources and emergency medical care for other patients without psychiatric needs. It is generally perceived among the stakeholders that many persistently mentally ill individuals go to the ERs for their psychiatric needs, are put on psychiatric hold by physicians or qualified law enforcement officers and end up in a restrictive inpatient unit costing taxpayers more money as opposed to less expensive treatment in the community (2010 Idaho State Planning Council on Mental Health Report, p. 6).

Barriers to Psychiatric Service Delivery

Most of the stakeholders in this study identified funding as very important factor when it comes to adequate and effective mental health service delivery in Idaho, they also believe that there are other contributing factors to the current mental health crisis in the U.S. Putting Idaho into perspective many of the respondents perceive that mental health has not received the necessary attention from both the community and the political leaders. Some of the stakeholders attributed this to the conservative belief system of Idahoans that does not believe that state government should expand and personal choice is better than having just one system of care. As the budget crisis deepens, the lack of strong commitment and attention to mental health services has indirectly favored making substantial cuts to behavioral health budgets when there is a need to balance budgets. Similarly, findings from this study also suggest that stakeholders perceive that political and community leaders have failed to understand the significant negative impacts of severe mental illnesses to the society (Frueh et al., 2012).

Another barrier to service delivery and a general consensus among the respondents is the failure of the political leaders to expand Medicaid and its privatization. Research has showed that Medicaid has emerged as the primary funder of public mental health services, and changes to Medicaid policy and program can have significant effects on the direction of changes in public mental health system (Buck, 2009). Most of the stakeholders highlighted that as a result of the economic recession, people lost their jobs and private insurance causing increased rate of depression and more people needing services from the public mental health system. According to most of the respondents, privatization of Medicaid for mental health services and failure to expand have created a huge gap in mental health service delivery as demands for services through Medicaid increase and more uninsured people need to access the public mental system . Similar to findings from previous research (Frueh et al., 2012; Honberg et al., 2011), decreasing reimbursement rates for psychiatric services, insurance eligibility (including Medicaid and private insurances) and state/federal regulations for psychiatric services have significantly contributed to various barriers perceived by the stakeholders.

Community Mental Health Services

Finally, findings from this research showed that Idaho has failed to recognize the untapped and inexpensive abilities of the community mental health system. Most of the stakeholders believe that the failure of the mental health system to provide prevention and early intervention services and maintain adequate and effective outpatient and follow-up services have created a vicious cycle where patients cycle from the community to jails, emergency rooms and inpatient psychiatric hospitalization (www.bazelon.org). Similar to most of the respondents, many researchers have documented the positive

impacts of adequate access to services provided in the communities and state funded community mental health clinics: such as residential treatment, day treatment services, case management, supportive and affordable housing, and medication stabilization. These services are perceived to enable individuals with severe mental illness live and function in the community, reduce burden on emergency rooms and law enforcement and help the current movement of deinstitutionalization for these patients (Honberg et al., 2011; Lutterman et al., 2004).

Strengths and Limitations

There were several strengths to this study, including all those inherent to qualitative research. The interview guide and questions were flexible that is, they were not restricted but were guided and redirected by the researcher in real time. The approach used in this study that tried to understand the topic from stakeholders experiences seem to be powerful and compelling. Though sample size was small and findings cannot be generalized to a larger population, however they could be transferable to another setting. Additionally, the data obtained from the participants reached a point of theoretical saturation where new data no longer brought additional insights to the research questions. However, research quality depends mainly on skills of the researcher and easily influenced by the researcher's personal biases and idiosyncrasies though this was limited through a procedure called bracketing.

Recommendations

Research

Although the research questions were focused on the impacts of funding on mental health services, future researchers should focus on studies that focus on understanding the root cause of the current mental health crisis in order to provide strategies and policies that could improve the public mental health system in Idaho and make significant contributions to mental health across the U.S.. To address this ongoing crisis, investigators could design studies to eliminate the root cause of the problems facing the persistently mentally ill by doing a root cause analysis – "a category of methods that is ubiquitous in health care quality-improvements programs" (www.bazelon.org). An approach that focuses on asking "why". This will be a retrospective approach to understand the underlying cause of the problem beginning with the adverse event or negative outcome and working backwards. Any model used for this research should track back to underlying factors that cause the series of events leading to crises. Following analysis, implementation of the best solutions that prevent problems and meet the needs of the clients are recommended.

Practice

Growing body of evidence has documented that the key to improving the mental health of a community is engagement, a core value of the community mental health movement. "Engagement means involving the full community, including people with mental illnesses, their families, government entities, faith-based organizations, for-profit and nonprofit corporations and the public in social change" (www.bazelon.org). Most of

the stakeholders believe that addressing the various problems of the community mental health system should be one of the major steps to address the current crisis.

Conclusion

Results from this study gave more insights into the plight of a vulnerable population that more often than not depends on a publicly funded healthcare system to meet their basic and treatment needs. Lack of commitment and inattention by policy makers and the society as a whole have created a system where mental health services have been historically underfunded across the U.S. and as a result of the most recent economic recession funding has further decreased. This has created a system where recidivism rates have increased for the persistently mentally ill as they cycle between various expensive settings such as the ERs, jail and restrictive inpatient hospital units because there is inadequate support and services to keep them in the community. The findings have implications for policies and strategies that could improve public mental health care for the persistently mentally ill.

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Appendix A

Key Informant Interview Guide

1. Please describe your background and experience in behavioral health in Idaho?
2. What is your understanding of Mental Health funding in Idaho?
    - What is your understanding of the recent Medicaid/budget cut in Idaho mental health service
3. How have the budget cuts affected the mentally ill patients seen in your facility/ organization/ private practice?
    - What are some specific differences observed before and after the cuts?
4. Can you describe any changes in availability and access to community resources since the budget cuts? (Resources such as availability of housing which focus on recovery and job training)
5. How have the budget cuts affected various Psychiatric services in your facility/organization/practice?
    - Can you give a specific example or tell a story about how the services and community resources have changed since the budget cuts?
6. What effect have the budget cuts had on the hospitalization of patients?
    - Can you give specific examples of how the budget cuts have affected hospitalization?
        - Are there changes in the type of services rendered at the hospitals?
        - Any change in quality of services?
        - Are there changes in the number of visits by patients?
        - How would describe the length of hospitalization before and after the cuts?
        - Is there any difference in frequency of readmission?
        - Is there any difference in the number of new admissions?
7. How did the budget cuts affect Emergency room admissions? Are there changes in the rate of ER admissions as a result of mental illness?
8. In a perfect world what type of community resources and services would you like to see? How far are we from an all-inclusive mental health care?

Law Enforcement official:

1. Can you describe your involvement with people with mental health disorder?
   Can you give you specific examples of your involvement?
2. How has contact between people with mental illness and the law changed over the last few years? (Arrests, charges and call to communities to help with mentally ill patients acting out)
   Can you give examples or tell a story about the changes since the major cuts?
3. What types of serious criminal activities are linked to mental illness?
   Can you give examples of such offences?
   What can be done about these activities linked to mental illness?
4. How much crime can be linked to substance abuse or use?
   Can you give examples of common offences associated with substance use or abuse?
5. How would you describe the Government role in addressing the needs of mentally ill patient to avoid interaction with the law?

Appendix B

CONSENT TO PARTICIPATE IN RESEARCH

Key stakeholder perceptions regarding budget cuts in Idaho mental health services

You are being asked to participate in a research study to examine the key stakeholder perceptions regarding budget cuts in Idaho mental health services. You do not have to be in this study and if you say yes, you may quit the study at any time. Please read this form carefully and ask any questions you may have before agreeing to take part in the study.

What the study is about: The purpose of this study is to examine the perceptions of key stakeholders in Idaho mental health services regarding the recent policy changes in the state's mental health funding. This study aims to examine the perceptions of key stakeholders on the impact of budget/Medicaid cuts on both mental health service utilization and engagement with the criminal justice system among those diagnosed with any mental illness and on the availability of community resources. In order to identify perceived changes over time, you will be asked to compare and contrast changes in utilization and resources that have occurred at two time points, three years before and three years after budget/Medicaid cuts. I am asking various professionals from Idaho mental health services and law enforcement/judicial agencies throughout Idaho to help me understand these perceived impacts.

What I will ask you to do: If you agree to be in this study, I will conduct an interview with you at your place of work or office. The interview will include questions about your background in Idaho mental health, mental health spending in Idaho, Medicaid /budget cuts, mental health service utilization and engagement/interaction of mental health service consumers with the criminal justice system. The interview will take about 30 - 60 minutes to complete. With your permission, I would also like to tape-record the interview.

Taking part is voluntary: Taking part in this study is completely voluntary. If you decide to take part, you are free to withdraw at any time. If you decide not to take part or withdraw from the study at any time, it will not affect your relationship Idaho State University.

Your answers will be confidential. The records of this study will be kept private. In any sort of report we make public we will not include any information that will make it possible to identify you. Research records will be kept in a locked file; only the researcher will have access to the records. If we tape-record the interview, we will destroy the tape after it has been transcribed, which we anticipate will be within two months of its taping. The only people who will see your responses will be the people who work on the study and those legally required to supervise this study. When we share the results of our study [in professional journals, at conferences, etc] we will not include your name. We will do our best to make sure no one outside the study will know that you are a part of the study.

It would not cost you anything to be in this study and you will not be paid for your time. The information obtained from this research will be useful to inform Idahoans, Idaho state

legislators, state and federal government on the perceived impact of recent policy changes and budget cuts in mental health services, and to help create more efficient community behavioral health policies that are people centered.

If you have questions: Please call the head of the study [Oluwafemi Abimbade at 609-372-6867] if you:

- Have questions about the study.
- Have questions about your rights.
- Feel you have been injured in any way by being in this study.

You can also call the Idaho State University Human Subjects Committee office at 208-282-2179 to ask questions about your rights as a research subject.

You will be given a copy of this form to keep for your records.

Statement of Consent: I have read the above information, and have received answers to any questions I asked. I consent to take part in the study.

Your Signature _____Date_____

Your Name (printed) _____

In addition to agreeing to participate, I also consent to having the interview tape-recorded.

Your Signature _____Date_____

Signature of person obtaining consent _____Date_____

Printed name of person obtaining consent _____Date_____