National Alliance on Mental Illness

State Mental Health Cuts:
A National Crisis

A report by the National Alliance on Mental Illness

March 2011

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Find Help. Find Hope.

State Mental Health Cuts: A National Crisis

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The National Alliance on Mental Illness (NAMI) is the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness. NAMI has more than 1,100 State Organizations and Affiliates across the country that engage in advocacy, research, support and education. Members are families, friends and people living with mental illnesses such as major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder(OCD), panic disorder, posttraumatic stress disorder (PTSD) and borderline personality disorder.

State Mental Health Cuts: A National Crisis

The recent tragic shooting of Congresswoman Gabrielle Giffords and the killing of six innocent citizens in Arizona focused national attention on the state of the public mental health system in Arizona and other states. Many asked how a tragedy like this could happen again, with chilling references to Virginia Tech. How did Jared Loughner fall through the cracks when the signs of a serious psychiatric crisis seemed so clear?

For NAMI, the National Alliance on Mental Illness, what happened in Tucson is all too familiar. Even during the best of economic times, youth and adults living with mental illness struggle to access essential mental health services and supports. Services are often unavailable or inaccessible for those who need them the most.

One in 17 people in America lives with a serious mental illnesses such as schizophrenia, major depression, or bipolar disorder.[1] About one in 10 children live with a serious mental disorder.[2]

In recent years, the worst recession in the U.S. since the Great Depression has dramatically impacted an already inadequate public mental health system. From 2009 to 2011, massive cuts to non-Medicaid state mental health spending totaled more than $1.8 billion dollars. And, deeper cuts are projected in 2011 and 2012. States have cut vital services for tens of thousands of youth and adults living with the most serious mental illness. These services include community and hospital based psychiatric care, housing and access to medications.

> I have schizo-affective disorder. I used to have a case worker, access to a counselor and group therapy, which were all part of my plan and helped me stay healthy and well. In July of 2010, due to budget cuts, the clinic here in town closed, and they laid off all the staff. I no longer have a case manager and only have peer support once a month, if I am lucky. I don't know how I will stay well without the medical care and treatment I need.
>
> —Individual living with mental illness

To make matters worse, Medicaid funding of mental health services is also potentially on the chopping block in 2011. The temporary increase in federal funding of Medicaid through the stimulus package will end on June 30, 2011. Medicaid is the most important source of funding of public mental health services for youth and adults, leaving people with mental illness facing the real threat of being cut off from life-saving services.

Communities pay a high price for cuts of this magnitude. Rather than saving states and communities money, these cuts to services simply shift financial responsibility to emergency rooms, community hospitals, law enforcement agencies, correctional facilities and homeless shelters.

1 National Institute of Mental Health, "The Numbers Count – Mental Disorders in America." www.nimh.nih.gov/publicat/numbers.cfm.

2 U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General*, Rockville, Md., 1999, PP408-409, 411.

Massive cuts to mental health services also potentially impact public safety. As a whole, people living with serious mental illness are no more violent than the rest of the population. In fact, it is well documented that these individuals are far more frequently the victims of violence than the perpetrators of violent acts.

However, the risks of violence among a small subset of individuals may increase when appropriate treatment and supports are not available. The use of alcohol or drugs as a form of self medication can also increase these risks.

Unfortunately, the public often focuses on mental illness only when high visibility tragedies of the magnitude of Tucson or Virginia Tech occur. However, less visible tragedies take place everyday in our communities—suicides, homelessness, arrests, incarceration, school drop-out and more. These personal tragedies also occur because of our failure to provide access to effective mental health services and supports.

This report documents the state-by-state funding changes for public mental health services since 2009 for youth and adults living with serious mental illness. These cuts are likely to worsen in 2011 and 2012.

The report also describes how states have chosen to implement these funding cuts. The report concludes with policy recommendations, focused on the steps that should be taken to ensure that valuable public resources are spent wisely and effectively. Crisis should be used as a vehicle for change, not as an excuse for abandoning some of our nation's most vulnerable citizens.

FUNDING OF MENTAL HEALTH SERVICES

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.)[3]

Two features mark the current budget crisis:

- Many states have significantly cut non-Medicaid mental health funding from 2009 to 2011, with deeper cuts projected in 2012.

- Enhanced federal funding of Medicaid in response to the recession will expire in June 2011, causing significant reductions in federal support for this important program. In response, many states are proposing changes that will further erode vital treatment and support for mental illness.[4]

State general funding of mental health care is the "safety net of last resort" for children and adults living with serious mental illness. Although Medicaid is an extremely important funding source, many people with mental illness do not qualify for Medicaid, either because their income is slightly

3 Lutterman, T., "The Impact of the State Fiscal Crisis on State Mental Health Systems: Fall 2010 Update," NASMHPD Research Institute, Inc., Oct. 12, 2010, Slide 46, http://www.nri-inc.org/reports_pubs/2010/ImpactOfStateFiscalCrisisOnMentalHealthSytems_Fall_2010_NRI_Study.pdf

4 K. Sacks and R. Pear, "States Consider Medicaid Cuts as Use Grows", *New York Times,* Feb. 18, 2010,

higher than the Medicaid threshold (which is well below poverty level in most states) or because they are too ill to take the steps necessary to apply and qualify for Medicaid. Additionally, Medicaid does not pay for some vital mental health services, most notably inpatient psychiatric treatment.

THE PRICE WE PAY: STATE MENTAL HEALTH CUTS

This report provides information about changes in state general funding of mental health services from 2009 (when the economic crisis went into full force) to 2011.

Uniform information about state-by-state funding is not available from any one source. Therefore, information about state funding was derived through a review of 2009 through 2011 budget documents in each state.

In conducting this research, we discovered significant fluctuations in the way states report and break down their budget information. Some states provide detailed information about the various sources of funding (state general funds, federal Medicaid, federal block grants, private grants etc.). Other states are not as precise. To the fullest extent possible, we included only state general funding of services for children and adults in deriving the data for this report. Medicaid funds (federal and state) are not included in this data. For a more detailed description of the methodology, see **Appendix VI**.

Between 2009 and 2011, states cumulatively cut more than $1.8 billion from their budgets for services for children and adults living with mental illness. The magnitude of these cuts in a number of states is staggering. **California** cut $587.4 million during this period, **Kentucky** $193.7 million, **New York** $132 million and **Illinois** $113.7 million.

The following 10 states cut the most in general funds from their mental health budgets between 2009 and 2011.

California	$587.4 million	Wisconsin	$107.1 million
Kentucky	$193.7 million	Massachusetts	$63.5 million
New York	$132 million	Ohio	$57.7 million
Illinois	$113.7 million	Alaska	$47.9 million
Arizona	$108.4 million	Washington, D.C.	$44.2 million

In recognition that individual states differ significantly in terms of population, numbers of children and adults living with mental illness and the size of the overall budget, it is important to also evaluate cuts in terms of the overall state general fund budget for mental health services. These results also illustrate the significance of these cuts in certain states. For example, **Kentucky** cut 47.5 percent of its total general fund mental health budget, **South Carolina** 22.7 percent and **Arizona** 22.7 percent.

The following 11 states made the largest cuts by percentage of their overall state mental health general fund budget from 2009 to 2011.

Kentucky	47%	Washington, D.C.	19%
Alaska	35%	Nevada	17%
South Carolina	23%	Kansas	16%
Arizona	23%	California	16%
Wisconsin	22%	Illinois	15%

A complete alphabetical chart of state-by-state changes to general funding of mental health services can be found in **Appendix I**. A complete chart of state-by-state changes ranked by percentage of cuts can be found in **Appendix II**.

WHAT DO CUTS OF THIS MAGNITUDE MEAN IN HUMAN TERMS?

With appropriate services, people living with serious mental illness can and do achieve recovery and independence in their lives. By contrast, lack of services often fosters worsened conditions and adverse consequences that cost communities dearly.

> My grandson had more than 20 brief hospitalizations in five years and was kicked out of four long-term residential hospitals. Finally, [he was sent to] … a residential treatment facility. There the staff was excellent, great therapy, and they kept trying until they got medications that worked. Why don't doctors tell parents about their options? It took five years to find that place. He stayed two-and-one-half years and came out a totally different person. At 16 he is now proud of who he is.
>
> —A grandparent

For youth and adults living with serious mental illness, these consequences include frequent visits to emergency rooms, hospitalizations, homelessness, entanglement with juvenile and criminal justice systems, the loss of critical developmental years, premature deaths and suicides.

It is well documented that even prior to the economic recession, more than one-half of people living with serious mental illness received no services in the previous year.[5] It is very likely that the significant cuts that have occurred in a number of states have further diminished access to needed services.

To understand the implications of cuts in individual states, one need only look at four states in different parts of the country.

- Ohio once had one of the top mental health systems in the country. Today, after several years of significant budget cuts, thousands of youth and adults living with serious mental illness are unable to access care in the community and are ending up either on the streets or in far more expensive settings, such as hospitals and jails.[6]

- After three years of budget cuts totaling $113.7 million, Illinois' community mental health system is in shambles. According to Christopher Larrison, professor of social work at the University of Illinois, these cuts in mental health funding, on top of already inadequate funding, has led to the "decimation" of community mental health services, particularly

5 R.C. Kessler *et al.,* "Prevalence and Treatment of Mental Disorder: 1990 to 2003," *New England Journal of Medicine,* 352 (2005) 2515.

6 C. Candisky, "Ohio's Mental-Health System Falls Far Short, Report Finds", *Columbus Dispatch,* Jan. 26, 2011, www.dispatch.com/live/content/local_news/stories/2011/01/26/ohio-mental-health-system-badly-flawed-report-says.html?sid=101

in the rural southern part of the state. "Imagine a small rural community where there are people with schizophrenia left untreated," said Larrison. "If you dry up the services, then the hospital emergency rooms and police, who are also at the breaking point, will have to deal with an increasing number of people suffering from untreated mental illness."[7]

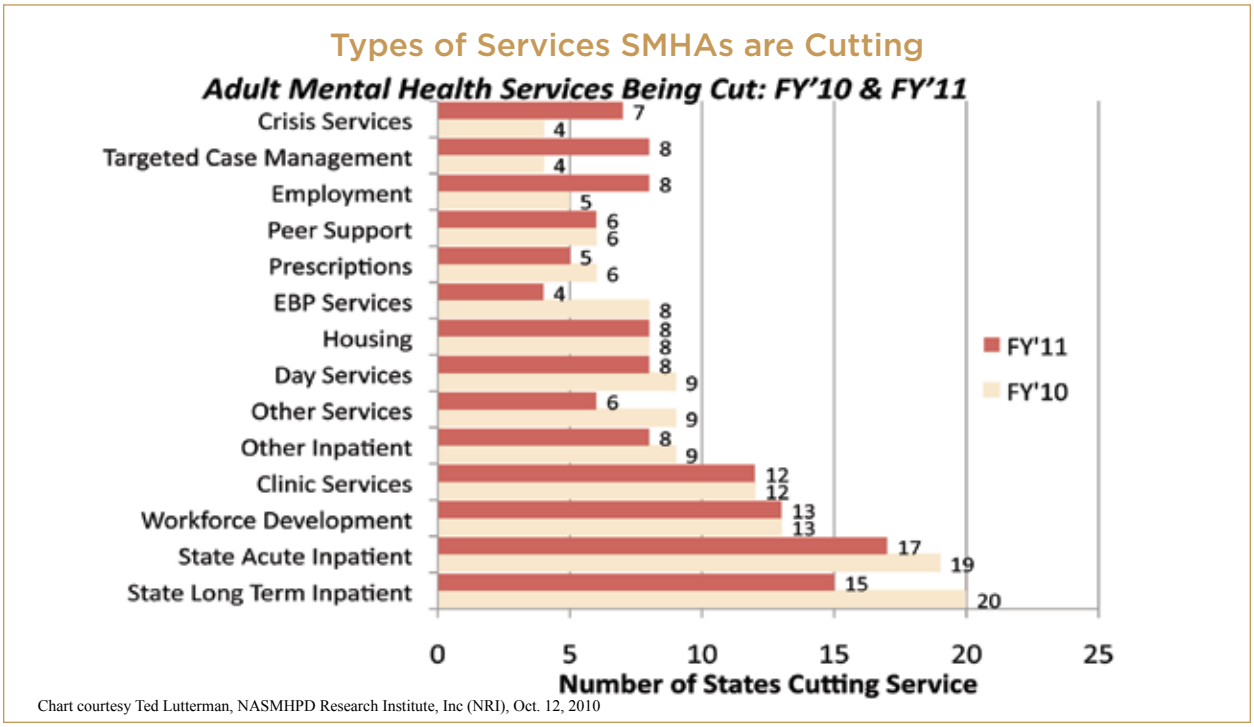

Chart courtesy Ted Lutterman, NASMHPD Research Institute, Inc (NRI), Oct. 12, 2010

- Arizona cut $108.4 million from its mental health budget between 2009 and 2011, reducing services to about 14,000 Arizona citizens living with mental illness and resulting in the elimination of case management, brand name medications, access to support groups and housing and transportation subsidies for people living with serious mental illness.[8]

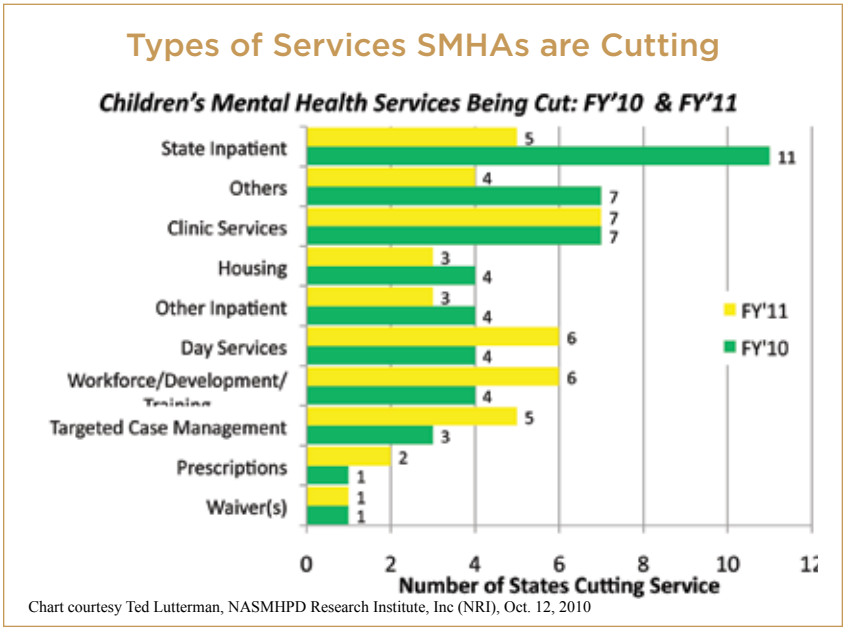

Chart courtesy Ted Lutterman, NASMHPD Research Institute, Inc (NRI), Oct. 12, 2010

- Rhode Island has cut mental health funding since 2008. Since 2008, Rhode Island experienced a 65 percent increase in the number of children living with mental illness boarding in public

7 P. Ciciore, "State Cuts to Community Mental Health Services Continues Disturbing Trend," News Bureau, Illinois, Aug. 5, 2010, http://news.illinois.edu/news/10/0805mentalhealthcuts.html

8 N. Santa Cruz and A. Powers, "Mental Health in Arizona: A Case Study," *Los Angeles Times*, Jan. 19, 2011, http://articles.latimes.com/2011/jan/19/nation/la-na-arizona-mental-health-20110120; H. Clarke Romans, Video Interview on Democracy Now, Jan. 11, 2011.

hospital emergency rooms, with no place to go for treatment.

These significant cuts in funding have occurred even as demand for public mental health services have increased. With loss of health insurance, more people have turned to the public system for mental health care. Many states report that demand for crisis services, emergency department services and acute and long-term psychiatric care have increased, even as budgets have decreased.[9]

Increased Demand for Mental Health Services During the Recession
Percentage of States Experiencing Increased Demand for Services

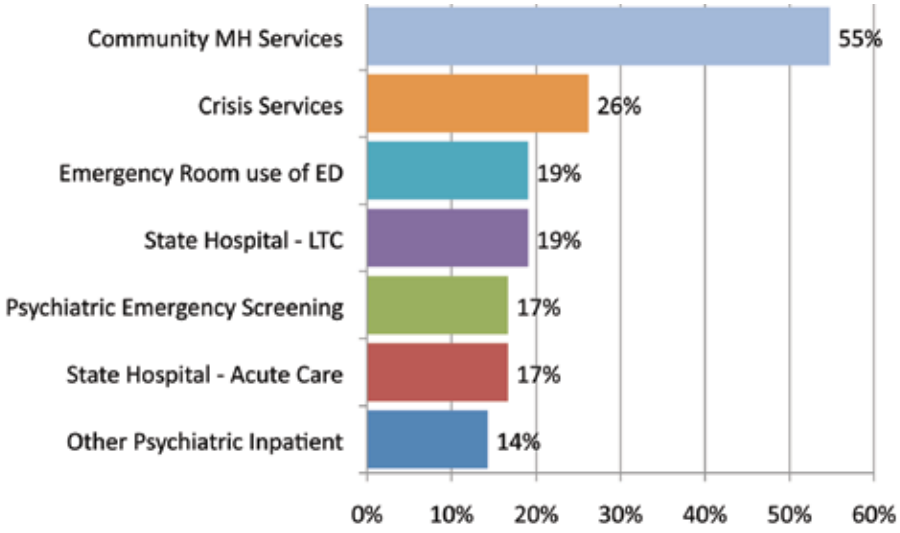

Chart courtesy Ted Lutterman, NASMHPD Research Institute, Inc (NRI), Oct. 12, 2010

WHAT SERVICES ARE BEING CUT?

In 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. However, as the recession deepened, budget cuts have increasingly focused on the elimination or downsizing of programs, services and professional workforce (such as psychiatrists, psychologists and social workers) as well as on reducing eligibility for services.

Specific services that have been eliminated or downsized include those that are most essential to helping 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[10]

9 Lutterman, T., *Id.*, slide 23.

10 Lutterman, *Id.*, slides 21 and 22.

In many states, critical safety net services for youth and adults living with mental illness have either already been eliminated or are threatened for elimination. For example:

- In October 2010, the Governor of Washington announced across the board cuts of $17.7 million in state mental health funding for 2011 and 2012. These cuts will reduce the availability of crisis and involuntary commitment services as well as outpatient and medication monitoring services. The cuts will also force additional closures or downsizing of inpatient psychiatric treatment facilities.[11]

- Kansas has cut $19 million in state mental health funding since 2008. As a consequence of these cuts, nine of Kansas' 27 Community Mental Health Centers are experiencing deficits and are in jeopardy of being closed. Most of these Centers serve rural areas of the state. This year, the Governor's budget proposes an additional $15 million in cuts, which would primarily impact services for uninsured children and adults living with serious mental illness.[12]

- The budget recently introduced by Texas legislators proposes a decrease of about 20 percent in funding to outpatient mental health services for children and adults. If implemented, this will mean that Bluebonnet Trails Community Services, which provided mental health care to about 10,400 people in eight central Texas counties in 2010, will lose funding for about 2,800 of these youth and adults. Bill Gilstrap, a 53 year old welder with bipolar disorder, has been receiving services from Bluebonnet Trails since 1997. "I'm a taxpayer, and I have a real sense of belonging in the community, " Gilstrap said. "The stark reality of my situation is that if I wasn't getting quality outpatient services, I'd be in a psychiatric hospital or I'd be in jail."[13]

- In Tennessee, $15 million in cuts have been proposed to the state's public mental health and alcohol and drug abuse authority. If implemented, these cuts will result in the closure of community mental health programs, alcohol and drug abuse treatment facilities and peer support centers.[14]

As the economic crisis has deepened, states have responded by eliminating psychiatric beds in hospitals and by cutting community services. In some cases, they have done both. See **Appendix III** for a chart showing the changes in numbers of people served in state hospitals from 2007-2009.

The Substance Abuse and Mental Health Services Administration (SAMHSA) maintains data on numbers of people living with mental illness served in inpatient and outpatient settings on its Uniform Reporting System (URS) database. Eleven states reported reductions in numbers of people served in **both** inpatient settings and community services between the years 2007 and 2009. Those states are **Alabama, Alaska, California, Idaho, Illinois, Nebraska, New Jersey, New Mexico, North Carolina, Virginia** and **Wyoming**. [15]

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11 J. Roszak, "My Turn: Can we Afford Mental Health Cuts*?" Kitsap Sun*, www,kitsapsun.com/news2011/jan28/my-turn-can-we-afford-mental-health-cuts/

12 K. Conner, "Mental Health Advocates DeCry Cuts", Hays Daily News, 2/8/2011, http://www.hdnews.net/Story/mentalhealth020811

13 A. Ball, "Mental Health Center Faces Big Cuts in State Budget", *Austin American Statesman,* Jan. 25, 2011, www.statesman.com/news/texas-politics/mental-health-centers-face-big-cuts-in-state-1209770.html

14 E. Schelzig, "Tennessee Agency Head Likens Budget Cuts to Amputation," MSNBC.com, 2/2/2011, www.msnbc.msn.com/id/41396321/ns/health-mental_health/

15 www.samhsa.gov/datoutcomes/urs

It should be noted that this data was derived before the worst of the state budget cuts. Our state-by-state budget research shows that the largest cuts to state funded mental health services took place in 2010 and even larger cuts are contemplated for 2011 and 2012. Considering the increased demand for services, states are being asked to serve more people with less money. A table comparing numbers of people served in 2007 with numbers of people served in 2009 can be found in Appendix IV.

In **Massachusetts**, where the Governor has proposed a $21.4 million cut to mental health services in FY 2012, one quarter of the beds in the state's psychiatric hospitals are slated for elimination. Mary Lou Sudders, who is the former commissioner of mental health in Massachusetts, says that cuts of this magnitude will "freeze up the entire public mental health system, so that no one will be able to transfer into Department of Mental Health inpatient beds, and individuals coming out of the hospitals will be at risk of being in the streets or in highly marginalized settings." According to Sudders, "There is no positive out of a cut of this magnitude."[16]

> Months turned into years. He was homeless, desperate for food and still refused to accept treatment. Even when he was involuntarily ordered to a hospital, he was not held long enough to stabilize. Many times, he would threaten suicide; as if it was the only option he had left.
>
> —A mother

INCREASED BURDENS ON LAW ENFORCEMENT

Increasingly, law enforcement, judges and emergency department physicians 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.

- In Nevada, a 12.4 percent reduction has been proposed for mental health funding in the state budget. If implemented, this would reduce the number of youth and adults receiving outpatient mental health services to 2,765 from 4,075. Clark County (Las Vegas) District Judge Jackie Glass, whose Mental Health Court would lose all funding, as would the Mental Health Court in Washoe County (Reno), told legislators that rather than save costs, cuts of this magnitude will lead to increased costs. "You are either going to pay less now, or more later", Judge Glass stated. "You will see…people (who lose mental health services) ending up in prison, jails, emergency rooms, homeless, harassing tourists and breaking into homes."[17]

- In Sacramento County, Calif., U.S. District Court Judge John A. Mendez blocked the County from cutting mental health services as a way to balance the budget. The Judge found that the county's plan to balance the budget by cutting mental health services to thousands of individuals would cause "catastrophic harm" and violate the Americans with Disabilities Act (ADA), resulting in potentially high litigation costs for the county.[18]

16 M. Levenson, "Mental Health Workers DeCry Planned Cuts", *Boston Globe,* Feb. 11, 2011, www.boston.com/news/local/massachusetts/articles/2011/02/11/mental_health_workers_decry_planned_cuts/?page=full

17 E. Vogel, "Mental Health Cuts Opposed", *Las Vegas Review Journal,* Feb. 2, 2011, www.lvrj.com/news/mental-health-cuts-opposed-115087449.html

18 C. Hubert and D. Walsh, "Sacramento County Mental Health Cuts Blocked by Federal Judge," *Sacramento Bee,* July 22. 2010,

- In Oklahoma, calls to the police involving psychiatric emergencies have increased 50 percent. Stacy Puckett, executive director of the Oklahoma Association of Chiefs of Police, says that "officers are traveling from one end of the state to the other and are out of their departments six, eight, 10 hours at a time" to try to find psychiatric beds for those who need them.[19]

> After her first break in 2009, my sister was admitted to a mental health facility which seemed to work. The outpatient doctor stopped her meds. When she had another breakdown, we tried to call the crisis center for help, but they kept saying not enough staff. We finally had to call 911 because she was trying to start a fire.
>
> — A brother

THE THREAT TO MEDICAID

The American Recovery and Reinvestment Act of 2009 (ARRA) provided federal fiscal relief to the states in the form of a temporary increase in the federal Medicaid matching rate (FMAP). As a consequence, $87 billion in additional federal funds have flowed to state Medicaid programs since ARRA went into effect.[20]

The temporary increase in FMAP was scheduled to end in December 2010. However Congress, in recognition of continuing economic pressures on the states, voted to extend the increase for six months through June 30, 2011, although at a lower rate. After June 30, 2011, the amount of Medicaid dollars states will draw down from the federal government could potentially decrease significantly. See **Appendix V** for a chart showing estimated state-by-state decreases in federal Medicaid revenues after June 30, 2011.

States may respond to the impending loss of federal Medicaid dollars in a number of ways. One response that could be particularly harmful would be to cut back on optional services currently available in state Medicaid programs. All Medicaid mental health services for children and adults fall into the optional category, with the exception of Early Periodic Screening Diagnosis and Treatment (EPSDT) for children.

Economic pressures in Medicaid may also facilitate renewed interest on states adopting managed care systems to control spending. Although managed care can have benefits through emphasis on the provision of evidence-based services, data collection and accountability, our experience in the past with Medicaid managed care has been mixed, at best.

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www.disabilityrightsca.org/news/2010_newsaboutus/2010-7-22-sacbee.htm

19 K. Zezima, "State Cuts Put Officers on Front Lines of Mental Care," *New York Times,* Dec. 4, 2010, www.nytimes.com/2010/12/05/us/05mental.html

20 Kaiser Commission on Medicaid and the Uninsured, "State Financial Conditions and Medicaid" October 2010 update, www.kff.org/medicaid/upload/7580.07.pdf, p.2.

Managed care systems established primarily to cut costs but not improve services can be particularly risky for vulnerable children and adults living with serious mental illness. Thus, if these systems are to be adopted, they must be designed and implemented carefully, with particular focus on ensuring that vital inpatient and community services for people living with serious mental illness are accessible and adequately funded.

> Enrolled in a program for assertive community treatment (PACT), he moved into a HUD apartment and was treated successfully over the next several years with a personalized approach to treatment. At one point, he was seen daily in his home. They even got him playing chess again. It was an indescribable relief. Then the state dropped his Medicaid coverage, leaving him with Medicare alone, which didn't cover case management. He was dropped from the PACT program. His medication use was sporadic. Over the next several years, he was in and out of the hospital, at one point doing time in the local jail.
>
> - Parents of a man living with schizophrenia.

HOLDING THE LINE

Even in the face of budget pressures, some governors or legislators are proposing budgets or legislation that either include targeted increases for mental health services or minimize proposed cuts to these services.

- In Georgia, responding to the settlement of a civil rights lawsuit focused on horrific conditions in psychiatric hospitals and the lack of community services, governor Nathan Deal's proposed budget for fiscal year 2012 recommends an increase of $35,650,039 in general fund dollars for mental health services for children and adults. The increase would go for expanding community-based services, such as supportive housing, assertive community treatment and crisis intervention and stabilization services. The governor's budget proposes a decrease in funding for inpatient treatment.

- North Carolina Governor Bev Perdue recommended 2012 budget includes a $75 million increase to North Carolina's Mental Health Trust Fund. This increase would be used to expand local inpatient hospital beds and housing programs for people living with serious mental illness, and care coordination services for people living with serious mental illness who are most at risk. Additionally, the increase would be used to develop systems of care characterized by integrated primary and behavioral health care services and integrated electronic record systems.

- Although Oklahoma Governor Mary Fallin's budget proposes cuts to all state agencies, her proposed cuts to agencies dealing with education, health and human services are lower than

in other areas, in recognition that these agencies provide vital services to the state's most vulnerable citizens. Moreover, the budget proposes additional funding for several initiatives designed to divert individuals living with mental illness and substance use disorders from incarceration into treatment, including expansion of a program facilitating mental health triage services for individuals experiencing psychiatric crises who come into contact with law enforcement.

- The Maryland legislature is considering enacting a "dime a drink" tax increase on the sale of beer, wine and hard liquor. If enacted, the proceeds will be used for safety-net health, mental health, addictions and developmental disabilities services.

POLICY RECOMMENDATIONS

1. Protect state mental health funding and restore budget cuts, but tie funding to performance.

States and communities cannot withstand further cuts to already inadequately funded public mental health systems for youth and adults. As this report documents, cuts in many states have already reached catastrophic proportions. As a matter of fiscal policy, cuts which result in the elimination of inpatient beds, crisis services and community supports are a penny wise and pound foolish strategy. States will inevitably end up spending more in costly emergency treatment, diversion of law enforcement personnel and correctional costs.

At the same time, legislators and taxpayers have the right to expect that resources spent on mental health services are spent wisely. Public dollars should be spent on services that work in preventing or alleviating mental health crises and in fostering recovery and independence. Citizens are entitled to better data about the services that are being provided and the outcomes of these services.

The state-by-state funding information contained in this report was derived through careful reviews of individual state budget documents between the years 2008 and 2011. It is difficult to make a strong case for protecting funding when critical information of this kind is lacking.

The time is long overdue for transparency about how much taxpayer money is being spent on mental health services, the specific services that are being funded, and the outcomes produced by these services. The federal government and state governments must collaborate to make this information far more accessible to the public and to consumers of these services than is currently the case.

2. Maintain adequate numbers of inpatient beds for psychiatric treatment.

The National Association of State Mental Health Program Directors (NASMPHD) reports that nearly 4,000 state psychiatric beds have been eliminated or are being considered for elimination, and 11 state hospitals have been closed or are being considered for closure since the economic crisis began. At the same time, community services, including crisis intervention and crisis stabilization programs have been eliminated. This, in effect, leaves few, if any options for responding to people in crisis.

History illustrates that eliminating hospital beds without appropriate community alternatives is cruel, irresponsible public policy and leads to shifting of costs to criminal justice systems and emergency departments rather than true cost savings.[21] The development of a strong infrastructure of community-based services will decrease the need for inpatient beds in some cases, but this infrastructure is today inadequate in most places.

A range of options for responding to youth and adults in crisis is needed, including mobile crisis teams, 24-hour crisis stabilization programs, and inpatient beds in community hospitals. It is also important to preserve beds in state hospitals, particularly for those individuals requiring intermediate or long-term care.

3. Invest in research on early detection and intervention in the treatment of serious mental illness in youth and adults.

Studies demonstrate that an average of eight to ten years pass from the onset of symptoms to intervention for young people living with mental illness. This is partially a function of stigma, acceptance, and barriers to accessing services. The price we pay for this lack of access to services is significant. Earlier identification and intervention could have worked in preventing the tragic consequences in Tucson.

The NIMH Recovery After an Initial Schizophrenia Episode (RAISE) project is an example of a study designed to facilitate more "coordinated and aggressive treatment" in the early stages of schizophrenia. The goal of RAISE is to develop interventions that can be tested in real world, clinical settings. More studies of this kind are needed to foster greater understanding of how to best identify and treat serious mental illness in children and adults on an early and timely basis.

4. Implement mental health screening and assessment programs.

The Virginia Tech and Tucson tragedies both appear to be examples of young people who manifested the signs of possible severe mental disorders during their secondary school years but were not properly identified and not linked with services and supports.

There have been repeated calls for early identification and screening for mental illness in children, adolescents and teenagers. These calls have come from the American Academy of Pediatrics in June 2010,[22] from the U.S. Preventive Services Task Force in April 2009,[23] from the Institute of Medicine in 2009[24] and from President Bush's New Freedom Commission on Mental Health in 2003.[25]

Screening for mental illness should become part of the routine clinical practice in primary care settings. Only then will we be able to close the existing eight- to 10-year gap between onset of symptoms and identification and avert the high costs of waiting so long.

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21 P. Earley, *Crazy: A Father's Search Through America's Mental Health Madness*, New York, G.P. Putnam and Sons, 2006, p. 71.

22 American Academy of Pediatrics, Task Force on Mental Health, 2010, www.aap.org/mentalhealth/

23 U.S. Preventive Services Task Force, Recommendations on Screening for Depression in Children and Adolescents, March, 2009, www.uspreventiveservicestaskforce.org/uspstf/uspschdepr.htm

24 Institute of Medicine, "Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities," National Academies Press, Washington, DC, 2009, http://books.nap.edu/openbook.php?record_id=12480&page=R1

25 President's New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America*, July 22, 2003, http://store.samhsa.gov/shin/content//SMA03-3831/SMA03-3831.pdf

> We have watched helplessly. The mental health system is in shreds and my son has not received follow-up or counseling. During the 35 years he has struggled with bipolar illness he has avoided hospitalization for eight years. His big [recent psychotic break] was inevitable without the staff and services of the mental health agencies.
>
> —A parent

5. Support programs designed to educate families, peers and the public about serious mental illness and how to respond to people living with these illnesses.

We have paid a significant price for the stigma surrounding mental illness. These illnesses are too often the target of ridicule, prejudicial assumptions and ignorance. Society rallies around people experiencing the symptoms of a heart attack or a diabetic crisis, but we run away from people manifesting the symptoms of a serious psychiatric crisis. Too often, even families and peers of people experiencing psychiatric symptoms don't know how to react or how to help.

Getting help for a person with serious mental illness is very complicated, far more complicated than most other illnesses. Mental health systems are fragmented and difficult to navigate even for those who are knowledgeable about how they work. Knowing when and how to help a loved one is critically important for family members and friends.

Programs such as NAMI's Family-to-Family, NAMI Basics and Peer-to-Peer have been developed and implemented to help families and peers support individuals in crisis. Other programs, such as Mental Health First Aid, are designed to de-sensitize members of the general community about mental illness. These programs should be implemented on a widespread basis. Ultimately, greater knowledge and awareness will lead to more effective, timely interventions that can prevent tragedies.

APPENDIX I: STATE MENTAL HEALTH EXPENDITURES FY2009-FY2011 (ALPHA ORDER)

State	FY2009 (Millions)	FY2011 (Millions)	Change 2009 - 2011 (Millions)		% Change
Alabama	$498.7	$511.0	$12.3	▲	2.5%
Alaska	$137.0	$89.1	$47.9	▼	-35.0%
Arizona	$477.6	$369.2	$108.4	▼	-22.7%
Arkansas	$71.4	$75.6	$4.2	▲	5.9%
California	$3,612.8	$3,025.4	$587.4	▼	-16.3%
Colorado	$152.0	$141.8	$10.2	▼	-6.7%
Connecticut	$676.0	$693.7	$17.7	▲	2.6%
Delaware	$78.6	$76.2	$2.4	▼	-3.1%
District of Columbia	$231.7	$187.5	$44.2	▼	-19.1%
Florida	$573.3	$574.5	$1.2	▲	0.2%
Georgia	$393.9	$395.9	$2.0	▲	0.5%
Hawaii	$225.7	$198.5	$27.2	▼	-12.1%
Idaho	$46.4	$41.1	$5.3	▼	-11.4%
Illinois	$753.0	$639.3	$113.7	▼	-15.1%
Indiana	$121.8	$118.2	$3.6	▼	-3.0%
Iowa	$170.6	$155.4	$15.2	▼	-8.9%
Kansas	$115.4	$96.5	$18.9	▼	-16.4%
Kentucky	$408.0	$214.3	$193.7	▼	-47.5%
Louisiana	$415.6	$403.8	$11.8	▼	-2.8%
Maine	$201.2	$211.6	$10.4	▲	5.2%
Maryland	$653.4	$627.2	$26.2	▼	-4.0%
Massachusetts	$685.4	$621.9	$63.5	▼	-9.3%
Michigan	$312.0	$287.5	$24.5	▼	-7.9%
Minnesota	$198.8	$201.6	$2.8	▲	1.4%
Mississippi	$262.5	$223.9	$38.6	▼	-14.7%
Missouri	$450.3	$466.8	$16.5	▲	3.7%
Montana	$123.1	$125.7	$2.6	▲	2.1%
Nebraska	$108.8	$113.0	$4.2	▲	3.9%
Nevada	$226.0	$186.8	$39.2	▼	-17.3%
New Hampshire	$104.0	$95.2	$8.8	▼	-8.5%
New Jersey	$811.5	$806.2	$5.3	▼	-0.7%
New Mexico	$44.5	$43.6	$0.9	▼	-2.0%
New York	$3,732.0	$3,600.0	$132.0	▼	-3.5%
North Carolina	$279.4	$337.9	$58.5	▲	20.9%
North Dakota	$64.1	$67.0	$2.9	▲	4.4%
Ohio	$511.9	$454.2	$57.7	▼	-11.3%
Oklahoma	$204.9	$200.1	$4.8	▼	-2.3%
Oregon	$306.4	$377.4	$71.0	▲	23.2%
Pennsylvania	$723.2	$689.4	$33.8	▼	-4.7%
Rhode Island	$84.6	$90.9	$6.3	▲	7.4%
South Carolina	$178.4	$137.9	$40.5	▼	-22.7%
South Dakota	$45.4	$47.2	$1.8	▲	4.0%
Tennessee	$166.2	$149.4	$16.8	▼	-10.1%
Texas	$923.4	$895.8	$27.6	▼	-3.0%
Utah	$91.4	$81.0	$10.4	▼	-11.4%
Vermont	$152.1	$156.6	$4.5	▲	3.0%
Virginia	$424.3	$385.8	$38.5	▼	-9.1%
Washington	$313.0	$278.5	$34.5	▼	-11.0%
West Virginia	$142.9	$152.4	$9.5	▲	6.6%
Wisconsin	$478.2	$371.1	$107.1	▼	-22.4%
Wyoming	$105.3	$102.2	$3.1	▼	-2.9%

APPENDIX II: STATE MENTAL HEALTH EXPENDITURES FY2009-FY2011 (PERCENTAGE, HIGH TO LOW)

State	FY2009 (Millions)	FY2011 (Millions)	Change 2009 - 2011 (Millions)		% Change
Kentucky	$408.0	$214.3	$193.7	▼	-47.5%
Alaska	$137.0	$89.1	$47.9	▼	-35.0%
South Carolina	$178.4	$137.9	$40.5	▼	-22.7%
Arizona	$477.6	$369.2	$108.4	▼	-22.7%
Wisconsin	$478.2	$371.1	$107.1	▼	-22.4%
District of Columbia	$231.7	$187.5	$44.2	▼	-19.1%
Nevada	$226.0	$186.8	$39.2	▼	-17.3%
Kansas	$115.4	$96.5	$18.9	▼	-16.4%
California	$3,612.8	$3,025.4	$587.4	▼	-16.3%
Illinois	$753.0	$639.3	$113.7	▼	-15.1%
Mississippi	$262.5	$223.9	$38.6	▼	-14.7%
Hawaii	$225.7	$198.5	$27.2	▼	-12.1%
Idaho	$46.4	$41.1	$5.3	▼	-11.4%
Utah	$91.4	$81.0	$10.4	▼	-11.4%
Ohio	$511.9	$454.2	$57.7	▼	-11.3%
Washington	$313.0	$278.5	$34.5	▼	-11.0%
Tennessee	$166.2	$149.4	$16.8	▼	-10.1%
Massachusetts	$685.4	$621.9	$63.5	▼	-9.3%
Virginia	$424.3	$385.8	$38.5	▼	-9.1%
Iowa	$170.6	$155.4	$15.2	▼	-8.9%
New Hampshire	$104.0	$95.2	$8.8	▼	-8.5%
Michigan	$312.0	$287.5	$24.5	▼	-7.9%
Colorado	$152.0	$141.8	$10.2	▼	-6.7%
Pennsylvania	$723.2	$689.4	$33.8	▼	-4.7%
Maryland	$653.4	$627.2	$26.2	▼	-4.0%
New York	$3,732.0	$3,600.0	$132.0	▼	-3.5%
Delaware	$78.6	$76.2	$2.4	▼	-3.1%
Texas	$923.4	$895.8	$27.6	▼	-3.0%
Indiana	$121.8	$118.2	$3.6	▼	-3.0%
Wyoming	$105.3	$102.2	$3.1	▼	-2.9%
Louisiana	$415.6	$403.8	$11.8	▼	-2.8%
Oklahoma	$204.9	$200.1	$4.8	▼	-2.3%
New Mexico	$44.5	$43.6	$0.9	▼	-2.0%
New Jersey	$811.5	$806.2	$5.3	▼	-0.7%
Florida	$573.3	$574.5	$1.2	▲	0.2%
Georgia	$393.9	$395.9	$2.0	▲	0.5%
Minnesota	$198.8	$201.6	$2.8	▲	1.4%
Montana	$123.1	$125.7	$2.6	▲	2.1%
Alabama	$498.7	$511.0	$12.3	▲	2.5%
Connecticut	$676.0	$693.7	$17.7	▲	2.6%
Vermont	$152.1	$156.6	$4.5	▲	3.0%
Missouri	$450.3	$466.8	$16.5	▲	3.7%
Nebraska	$108.8	$113.0	$4.2	▲	3.9%
South Dakota	$45.4	$47.2	$1.8	▲	4.0%
North Dakota	$64.1	$67.0	$2.9	▲	4.4%
Maine	$201.2	$211.6	$10.4	▲	5.2%
Arkansas	$71.4	$75.6	$4.2	▲	5.9%
West Virginia	$142.9	$152.4	$9.5	▲	6.6%
Rhode Island	$84.6	$90.9	$6.3	▲	7.4%
North Carolina	$279.4	$337.9	$58.5	▲	20.9%
Oregon	$306.4	$377.4	$71.0	▲	23.2%

APPENDIX III: CHANGES IN NUMBERS OF PEOPLE SERVED IN STATE HOSPITALS 2007-2009

State	People Served in State Hospitals 2007	People Served in State Hospitals 2009	Change: People Served in State Hospitals
Alabama	3,550	3,346	-204
Alaska	1,291	884	-407
Arizona	537	401	-136
Arkansas	1,085	992	-93
California	8,050	9,593	1,543
Colorado	3,401	2,608	-793
Connecticut	1,490	1,568	78
Delaware	555	365	-190
District of Columbia	not reported	827	n/a
Florida	4,291	5,441	1,150
Georgia	14,033	9,449	-4,584
Hawaii	414	345	-69
Idaho	758	872	114
Illinois	8,126	8,742	616
Indiana	1,519	1,570	51
Iowa	1,793	1,024	-769
Kansas	3,595	4,058	463
Kentucky	6,945	6,715	-230
Louisiana	1,938	4,362	2,424
Maine	555	534	-21
Maryland	2,890	2,337	-553
Massachusetts	1,551	1,485	-66
Michigan	1,483	1,398	-85
Minnesota	2,451	2,187	-264
Mississippi	4,273	5,300	1,027
Missouri	7,393	6,235	-1,158
Montana	681	806	125
Nebraska	1,946	539	-1,407
Nevada	2,997	3,103	106
New Hampshire	1,625	1,751	126
New Jersey	3,420	4,125	705
New Mexico	1,063	1,090	27
New York	10,814	11,571	757
North Carolina	11,963	6,615	-5,348
North Dakota	644	635	-9
Ohio	not reported	5,525	n/a
Oklahoma	2,574	1,940	-634
Oregon	1601	1,465	-136
Pennsylvania	3,221	3,125	-96
Rhode Island	1,020	800	-220
South Carolina	3,199	2,780	-419
South Dakota	2,238	2,201	-37
Tennessee	7,075	3,600	-3,475
Texas	15,242	14,043	-1,199
Utah	664	673	9
Vermont	231	246	15
Virginia	5,697	5,309	-388
Washington	3,374	3,239	-135
West Virginia	1,411	1,314	-97
Wisconsin	5,307	5,571	264
Wyoming	349	457	108
	172,323	**165,161**	**-13,514**

Source: Substance Abuse and Mental Health Services Administration (SAMHSA), "The Uniform Reporting System Database," Feb. 27, 2011, www.samhsa.gov/dataoutcomes/urs.

APPENDIX IV: CHANGES IN NUMBER OF PEOPLE SERVED BY THE STATE MENTAL HEALTH AUTHORITY (SMHA) 2007-2009

State	Total People Served by SMHA System 2007	Total People Served by SMHA System 2009	Change: Total People Served SMHA
Alabama	102,025	96,084	-5,941
Alaska	24,675	15,872	-8,803
Arizona	143,964	158,855	14,891
Arkansas	69,228	73,094	3,866
California	658,314	528,245	-130,069
Colorado	75,198	82,804	7,606
Connecticut	79,221	84,070	4,849
Delaware	9,756	9,756	0
District of Columbia	not reported	17,837	n/a
Florida	262,917	270,617	7,700
Georgia	147,648	150,765	3,117
Hawaii	17,147	18,566	1,419
Idaho	23,417	10,466	-12,951
Illinois	179,580	168,513	-11,067
Indiana	87,641	99,879	12,238
Iowa	81,803	89,642	7,839
Kansas	103,790	114,782	10,992
Kentucky	136,692	143,587	6,895
Louisiana	47,341	57,658	10,317
Maine	48,696	52,901	4,205
Maryland	92,738	105,926	13,188
Massachusetts	27,297	27,745	448
Michigan	207,407	219,238	11,831
Minnesota	85,802	178,148	92,346
Mississippi	92,003	99,432	7,429
Missouri	73,808	77,363	3,555
Montana	26,248	26,834	586
Nebraska	37,163	28,321	-8,842
Nevada	28,513	32,035	3,522
New Hampshire	46,909	49,953	3,044
New Jersey	351,339	327,560	-23,779
New Mexico	72,959	26,024	-46,935
New York	615,379	687,867	72,488
North Carolina	246,609	229,623	-16,986
North Dakota	15,493	16,593	1,100
Ohio	309,594	338,655	29,061
Oklahoma	44,002	52,089	8,087
Oregon	109,758	105,820	-3,938
Pennsylvania	299,037	454,811	155,774
Rhode Island	26,886	29,266	2,380
South Carolina	88,331	89,647	1,316
South Dakota	11,918	12,593	675
Tennessee	170,727	194,344	23,617
Texas	240,443	279,709	39,266
Utah	38,658	42,040	3,382
Vermont	20,806	21,711	905
Virginia	121,696	104,074	-17,622
Washington	123,614	128,705	5,091
West Virginia	58,918	60,130	1,212
Wisconsin	84,890	94,319	9,429
Wyoming	18,081	17,045	-1,036
	6,086,079	**6,401,613**	**297,697**

Source: Substance Abuse and Mental Health Services Administration (SAMHSA), "The Uniform Reporting System Database," Feb. 27, 2011, www.samhsa.gov/dataoutcomes/urs.

APPENDIX V: PROJECTED LOSS OF FEDERAL MEDICAID FUNDS FY 2012

State	Loss of Enhanced Medicaid Match FY 2012* (in millions)
Alabama	$133
Alaska	$57
Arizona	$353
Arkansas	$129
California	$1,881
Colorado	$159
Connecticut	$204
Delaware	$48
District of Columbia	n/a
Florida	$794
Georgia	$234
Hawaii	$90
Idaho	$53
Illinois	$553
Indiana	$239
Iowa	$112
Kansas	$87
Kentucky	$159
Louisiana	$395
Maine	$88
Maryland	$290
Massachusetts	$501
Michigan	$379
Minnesota	$282
Mississippi	$151
Missouri	$297
Montana	$40
Nebraska	$63
Nevada	$79
New Hampshire	$54
New Jersey	$408
New Mexico	$134
New York	$1,407
North Carolina	$343
North Dakota	$22
Ohio	$514
Oklahoma	$203
Oregon	$156
Pennsylvania	$668
Rhode Island	$74
South Carolina	$148
South Dakota	$23
Tennessee	$239
Texas	$851
Utah	$58
Vermont	$39
Virginia	$293
Washington	$338
West Virginia	$81
Wisconsin	$228
Wyoming	$23

*Based on amounts by the Council of State Governments for actual amounts funded for federal extension of enhanced Medicaid match.The Council of State Governments, Capitol Facts and Figures, Extension of Enhanced Medicaid Benefits to States (FMAP), http://knowledgecenter.csg.org/drupal/content/extension-enhanced-medicaid-benefits-states-fmap

APPENDIX VI: METHODOLOGY

Fiscal information for this report was derived from state budgets and fiscal documents from FY2008 through FY 2011 and consisted primarily of state general fund expenditures excluding state Medicaid allocations. Wherever possible, reporting is limited to dollars spent on inpatient and community mental health services for children and adults and does not included expenditures for developmental disability or substance abuse services. However, due to variations in state budget reporting, some expenditures for substance abuse or developmental disabilities may be included in a few states.

Sources for service utilization data include the SAMHSA Uniform Reporting System (URS) www.samhsa.gov/dataoutcomes/urs/ and publications from the National Association of State Mental Health Program Directors (NASMHPD). Examples of the impact of state budget cuts on service systems and individuals were drawn from media coverage and from individuals who courageously shared their personal stories with NAMI.

National Alliance on Mental Illness

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