Mental health care cuts hit rural Wisconsin

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Austerity and poverty have been a way of life for many working families in northwestern Wisconsin for decades, based on low wages and poor to no benefits. An added harshness arrived December 31 when a 36-year-old mental health facility for inpatient care and its companion 19-year-old outpatient care clinic were shuttered in Cumberland, Wisconsin, a small, incorporated community of 2,170 people. Both entities are owned by the independent community hospital.

Cumberland Healthcare hospital's inpatient mental health unit has varied over the years in the numbers of beds provided to its service region of as many as five surrounding counties. Its 10 beds were closed at end of the year, as well as the companion outpatient mental health unit known as Northwest Regional Center.

The outpatient clinic cared for approximately 850 persons from the northwestern quadrant of Wisconsin. A psychiatrist and support staff of mental health social workers and adult and child-adolescent therapists staffed the facility. With the closure of the inpatient and outpatient units, some 29 full- and part-time jobs are being eliminated.

To date, no local replacement care entity has been identified or established. Patients and their families are therefore left to decide for themselves where to seek further needed care in either Eau Claire, Wisconsin, almost 60 miles away; Duluth, Minnesota, 97 miles away; or Rhinelander, Wisconsin at 143 miles.

Dr. Charles Mayo, the staff psychiatrist, reported, during a presentation to the 7th annual conference of the National Alliance on Mental Illness that the closures will cause a crisis of care for many patients and their families for mental health services in the region. The most common problems include acute and chronic major depression, bipolar disorder, severe anxieties, the varied presentations of psychosis and the schizophrenias, drug abuse/chemical dependency, and dementia.

Health care generalists, mental health professionals and patients and their families understand the critical role that preventative outpatient mental health plays in the avoidance of mental health crises and emergencies. But over the years, vital social services across the board have fallen under the axe of budget cutbacks.

The Cumberland hospital's CEO, Mike Gutsch, reported to the Rice Lake, Wisconsin *Chronotype*, "It's a financial issue, really, it's draining us." He explained that the needs for mental health attention were increasing, while reimbursements continued to fall.

Gutsch pointed out that the federal and state administered Medicare and Medicaid programs fell far short of covering the costs of delivering the needed mental health care. Consequently, the Cumberland hospital was compelled to take from the general hospital's other revenue sources to fund both outpatient and inpatient mental health facilities.

For the year 2011, the small general hospital was left $500,000 short in its struggle to continue the care for the mental health of its citizenry, while keeping its doors open to provide general medical care. Gutsch announced that loss projections for 2012 were similar.

A technique of gradualism has been used over the last numbers of years to pare away reimbursements from Medicaid and Medicare to medical, dental and mental health care providers for many, if not all, types of care rendered. The poor and mentally ill and their families will unquestionably bear the greatest burden of suffering and misery.

Nine years ago, in the *Health Affairs* online journal, Paul S. Appelbaum, then president of the American Psychiatric Association, reported, "Over a little more than a decade, I have witnessed the progressive and systemic defunding of psychiatric services in Massachusetts and—despite some regional variation—in the United States as a whole.

As a result, he reported, provision of mental health treatment in has "become a money-losing proposition" and that "people in need of treatment are finding it more difficult, if not impossible, to get care." Applebaum added that unless remedial steps were taken "we are likely to see the slow implosion of mental health services in many parts of the United States."

Almost a decade later, this is what can be seen in communities across the country in tandem with the growth of social inequality. The Wisconsin Budget Project (an initiative of the Wisconsin Council on Children and Families) reported November 20, 2012: "Income inequality continues to grow in Wisconsin and the United States, producing an ever-widening chasm between the rich and the poor."

According to an early November report released by the Economic Policy Institute and Center on Budget and Policy Priorities, "Wisconsin is keeping pace with the national trend of dramatic increases in inequality. By the late 2000s,

Wisconsin had a greater degree of income inequality than the most unequal states did 30 years ago."

The Wisconsin Budget Project further notes, "Of all the income in the state, six of every ten dollars flows to just two of every ten residents—the richest fifth of the population. The remaining four of ten dollars is split across the bottom 80 percent of the state population."

These economic figures find real expression in the lives of patients and their families trying to cope with mental health issues. A parent from the Cumberland referral region discussed her and her son's life struggles with his schizophrenia, diagnosed when he was a teenager. For privacy reasons, she asked not to be identified.

"At the onset of his illness," she said, "the (Cumberland) services were essential as it is the only mental health facility in the area. He had to be hospitalized at least six times and, were it not for something available locally, we would have had to travel (much farther) to Eau Claire and Duluth, *if beds were available.* "

She added, "I can't imagine where some of the clients are going to receive services. These are generally very poor people who often have a difficult time making it through a day. To organize and pay for a trip to another facility an hour or more away will be impossible for some … it is quite easy to see how it would be a hardship for lower income families (given need for) gas, reliable car, time involved, who can take time off from work, etc."

We asked whether her son's illness had made him more vulnerable to altercations with law enforcement.

"My son has had numerous interactions with the law," she said, "often due to his paranoia, and also due to the people who will accept him and who he ends up associating with. (Once) he stole his dad's auto and drove to the Canadian border and tried to cross it with $20 in his pocket. This is just one example of what we have to deal with, while still working and trying to function in society.

"(When he's needed to go to hospital) he wouldn't go voluntarily, so three (of his family) had to do a petition to commit him. It always involves law enforcement picking him up and bringing him to a hospital. I don't know of any other illness that requires the person to be publicly handcuffed to be taken to the hospital."

We asked what goes through her mind when big business politicians lament that there is "no money" for essential social services, she said, "There's always plenty of money for prisons, which are packed with people who should be in hospitals instead. A few months of medication, some counseling and follow-up would diminish the jail and prison population in every single facility in every single town/city in the US."

When asked how sanity is possible in a society attempting to throw so many problems upon individuals and families, while providing no social solutions to socially rooted maladies, she replied, "You're right, the work demands energy and sometimes there is little energy left after that. It requires a dogged drive to educate oneself about what the hell it is that is going on with the affected person. And some people don't have the wherewithal to get that information, for a number of reasons.

"I cannot imagine how anyone with fewer resources manages life with a disabled person. I don't know how we have, for that matter. It is a full-time job. It is expensive. It is exhausting."

The populations of Illinois and Wisconsin are among the top 10 states and districts that suffered funding cuts for mental health from 2009 to 2011, according to the National Alliance on Mental Illness. Kentucky decreased by 47.5 percent; Alaska, 35 percent; South Carolina, 22.7 percent; Arizona, 22.7 percent; Wisconsin, 22.4 percent; Washington, D.C., 19.1 percent; Nevada, 17.3 percent; Kansas, 16.4 percent; California, 16.3 percent; Illinois, 15.1 percent.

Major closures of mental health hospitals occurred in several states, including Georgia, New Jersey, California and Alabama.

In May 2010 the Treatment Advocacy Center and the National Sheriffs' Association published a survey of the United States, documenting that more mentally ill persons are in the US prison system than in mental health facilities, by a factor of more than three.

The study also concluded that at least 16 percent of incarcerated persons have a serious mental illness, up from a similarly conducted study in 1983 reporting 6.4 percent. Further, studies indicate that fully 40 percent of individuals with serious mental problems have been incarcerated at some time in their lives.

In 1955, there existed one psychiatric bed for every 300 Americans. In 2005, there was one bed for every 3,000 citizens, many of which were not available due to court ordered forensic cases.

Authors of the 2010 study insist that the United States has returned to "the conditions of the 1840s by putting large numbers of mentally ill persons back into jails and prisons." This was an era in which the reformist Dorothea Dix campaigned against the inhuman practice of jailing persons for mental illness, initiating a movement for the building of state mental hospitals, with the assertion that the mentally ill should be treated rather than punished.