THE IMPACT OF 2005-2010 CALIFORNIA STATE BUDGET CUTS ON MENTAL HEALTH PROVIDERS IN NORTHERN CALIFORNIA

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THE IMPACT OF 2005-2010 CALIFORNIA STATE BUDGET CUTS ON MENTAL HEALTH PROVIDERS IN NORTHERN CALIFORNIA

A Project

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Abstract

of

THE IMPACT OF 2005-2010 CALIFORNIA STATE BUDGET CUTS ON MENTAL HEALTH PROVIDERS IN NORTHERN CALIFORNIA

by

Sara Elizabeth Meadows

From 2005-2010, there have been significant budget cuts to mental health services in Northern California. Resources have been further limited to those receiving the services, and mental health providers have been affected as a direct result of the budget cuts. This is an exploratory study attempting to investigate how mental health providers are responding both personally and professionally to budget eliminations in the State of California. The primary purpose of the study is to explore the stress of providers in Northern California, and to hopefully highlight the importance of support for the providers, so that they are able to stay productive and healthy in the field of mental health and provide much needed services to the citizens of California. A survey was administered to 30 mental health providers in Northern California who have provided services between 2005-2010. The data for this study was analyzed through two different methods; content analysis and statistical analysis. Based on the study findings, there is a
correlation between the budget cuts and increased stress for providers of mental health services. Particularly, seventy-six percent of the respondents reported increased levels of work related stress, and one-hundred percent of the respondents reported concern about job security.

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________________________
Date
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Chapter 1
INTRODUCTION

Consider for a moment the experience of an on-call mental health provider employed by a local wrap-around mental health service for adults with severe and persistent mental illness. The worker is contacted by a staff member from a Board and Care facility in regards to one of their residents. The client has broken out two windows, and is screaming at the voices she hears in her head. The staff member is requesting support. The on call mental health provider responds to the home after contacting law enforcement. Law enforcement responds 2 hours later, and the provider has spent that time trying to defuse the situation. Law enforcement refuses to place the client on a 5150 hold, citing that it does not appear that client is a danger to himself or others. They also state that they are not equipped to respond to mental health concerns, due to the budget cuts, and defer to the on-call worker who provides the services. Board and care staff want the client out of the home, law enforcement refuses to escort the client, and the on-call worker has few options for client placement at 4 am in the morning. All the while, the client is screaming to himself, unable to quiet the noise in his head. What is the on-call worker supposed to do?

Anyone familiar with the demands of providing mental health services is most likely also familiar with its correlation with work-related stress. Occupational stress can be defined as negative physical and emotional responses that occur when the job requirements do not match the capabilities, resources or needs of the employee (Braaten,
Mental health providers are forced to navigate the difficult terrain of providing direct services; including client contact and collaboration with community systems.

**Purpose of the Study**

Over the past 5 years, the State of California has been forced to make concessions in funding to different social services in an attempt to balance the budget. As a result, there have been eliminations in the budget directly related to mental health. When the 2010/2011 budget passed, $131 million in social services were eliminated from the California budget (Department of Finance, State of California website, 2010). Invariably, the combination of the decrease in funding for mental health and providers with existing work related stress should be a relationship of concern and cause for further investigation.

The question is, how have mental health providers been affected by recent budget cuts over the past 5 years?

**Background of the Problem**

The process to convert hospital-based mental health services to community mental health services in the state of California dates back to 1967 with the Lanterman Petris Short Act (Mental Health Association in California website, n.d.). As the years progressed, the funding for mental health services was diversified, compensated by other funds, and matched by federal funding (Department of Finance, State of California website, 2010). As the state budget became larger and more complicated, it has increased by almost $180 million dollars since 1976 (California Department of Health Care Services website, 2007). Specifically, over the past 5 years, it has increased by almost
$25 million dollars alone (Department of Finance, State of California website, 2010). By 2007, California had become the eighth largest economy in the world, and with that distinction came the issues associated with falling state revenues and budgetary issues (CCSCE, 2008). As with any budget, when the costs outweigh the revenue, and exclusions from the budget must occur in order to balance it. The exclusions in the past 5 years have been severe, including line-item vetoes that eliminated $133 million from mental health services for students in special education ("Cuts could face legal challenges", 2010). Strain on a system affects all parts, and for those providing mental health services with funding allotted by a state in financial crisis, the services and the workers providing them could be affected by increased stress.

Social services jobs, particularly mental health positions, have long been associated with stress by the people who know someone or are themselves working in the mental health field (Moore & Cooper, 1996). For most mental health workers, the long hours, full caseloads and use of self when serving clients can create a stressful work environment. A provider can only hope to be part of an agency or work environment that attempts to stymie additional stress by providing opportunities for growth, stress relief, and professional support. Many agencies in Northern California rely on county and state funding in order to provide services. When that funding is jeopardized, the pre-existing stress experienced by providers is amplified by increased expectation for productivity and outcomes.
Statement of the Research Problem

The problem the researcher sees is the potential negative impact that increased stress on mental health providers could have on both the providers and the services being provided. As providers become more stressed, the affect that stress has on both their personal and professional lives could be unfavorable. The amount of pressure being placed on providers to be present and do effective work in a system that is experiencing significant changes might be more than providers can handle, which could lead to an increase in providers leaving the mental health field. In turn, those potential losses in employees could place more pressure on the workplace, other providers, and possibly social service provision in the state of California. The concept that this cycle could continue and become more devastating with each turn makes this issue more prominent as time goes by. It is even possible that this cycle could deter people from wanting to work the mental health field, which would be so very unfortunate, and eventually have a trickle-down effect in society.

It is the researcher’s belief that if there were a correlation shown between recent budget changes and increased stress, effective stress management in the workplace would be addressed more aggressively by agencies and service providers.

Purpose of the Study

This study aims to bring to light some of the feelings of mental health providers currently working in the field, under the pressure of the California state budget changes. The primary purpose of the study is to explore the stress of providers in Northern
California, and to hopefully highlight the importance of support for the providers, so that they are able to stay productive and healthy in the field of mental health and provide much needed services to the citizens of California. The secondary purpose is to institute support systems within the field, to provide additional support to mental health providers in conjunction with budget cuts and systematic instability. Additional support would help to decrease liability for providers, and increase productivity. The work itself is stressful enough as it is, and the assumption could be made that providers would be under even more stress with the budget reduction, which would affect both the provider and the provision of the services. The study also aims to determine if there is a correlation between California state budget cuts and increased work related stress.

Theoretical Framework

The ecological perspective focuses on the idea of the relationship of individuals and their surroundings. The concept ‘goodness of fit’ details the balance or imbalance of resources and demands, and the effect on the person (Schriver, 2004). The study suggests that the demands for providers of mental health services outweigh the resources, and that as a result, the goodness of fit is not positive for the provider. This perspective provides a context to investigate the potential interactions between mental health providers and places of employment, the systems with which they interact, and one another. The interrelatedness of this study is a perfect example of viewing this problem through the lens of the ecological perspective.
Another theory that could be applied to this topic is the relational theory. Having a deeper understanding about ecosystems is an integral part of the learning process: how organizations, institutions and other important bodies create a web around individuals and influence behavior (Coady & Lehman, 2008). Mental health providers are entrenched within the environment they provide services, and how that environment functions undoubtedly affects how those services are provided. If the web that surrounds mental health workers is relatively free of major flaws, providers will work within that web with ease. Conversely, if that web is under stress, that stress will eventually filter down to providers.

**Definition of Terms**

Mental health services – Services that aim to support a person’s overall emotional and psychological conditions including one that may require psychological attention, support from others, and/or medication. Sacramento County Mental Health Treatment Center (SCMHTC) – The mental health triage/treatment center funded by the County of Sacramento.

**Assumption**

The assumption is made that mental health providers in Northern California are experiencing a higher level of work-related stress as a result of eliminations from the California State Budget. The researcher is also assuming that respondents to the survey will respond accordingly.
Justification

The researcher argues that in order for mental health services to be provided in an ethical manner, providers need to feel supported with institutional and agency networks. The researcher also argues that system partners need to employ some level of protection from the fluctuations in the budget, and recognize the need for healthy providers in Northern California, especially those being funded by state and county monies.

Limitations

The population that was surveyed for this study included mental health providers, in several service settings, throughout Northern California. Information collected is limited to this geographical area.
Mental health services in California are in a state of crisis, and over the past five years, the current condition of state and county budgets has created opportunities to eliminate necessary services to thousands of Californians who receive services (California Mental Health Director’s Association website, 2006). The providers of these services, who already encounter work related stress on a daily basis, may also feeling increased stress as services are being eliminated, reduced and reorganized in order to alleviate some of the pressure on the budget (Department of Finance, State of California website, 2010). The provision of mental health services in California in this crucial time has become increasingly difficult (Braaten, 2000). The question then becomes – how have mental health providers been affected by recent budget cuts in Northern California?

A Brief History

In 1969, the California Community Mental Health Services Act was enacted, modeled after national mental health legislation that effectively ‘deinstitutionalized’ services for the mentally ill, moving the provision of services from state hospitals to community clinics (Ryan, 2007, p. 2). The Short-Doyle Act (Short-Doyle Act, 1959) was to serve as the funding source for such services, and the language indicated that state hospitals would no longer be the primary funding source for the mentally ill. However, in 1972 and 1973, Governor Reagan vetoed such provisions, and the state did not distribute the savings achieved through closing many of the state hospitals (Frank & Welch, 1982).
There are four major sources of mental health funding in the state of California. They include Realignment Revenues, State Categorical Funding (*AB 2034*, 2000), Federal Funding (*Substance Abuse and Mental Health Services Administration*, 1992), and the Mental Health Services Act (*Proposition 63*, 2004).

When the mental health system in California was created, it was intended to provide services to the extent that resources were available. The funding base was inadequate from the start, and subject to fluctuations in state and local government budgets. Due to inflation during the 1970’s and 1980’s, state allocations to counties were severely diminished (Department of Finance, State of California website, 2010). During the 1980’s, cost of living increases were not made (Social Security Online website, n.d.). In 1990, the State of California faced a $15 billion state budget shortfall (CATO Institute: Individual Liberty, Free Markets, and Peace website, 1991). This would have resulted in even more cuts to mental health services. This crisis precipitated the enactment of the first funding source for mental health services in California, called Realignment Funding (*Bronzan-McCorquodale Act*, 1991).

Realignment Funding was enacted in 1991 with the passage of the Bronzan-McCorquodale Act (*Bronzan-McCorquodale Act*, 1991). As a result, Realignment funds flowed directly to counties, bypassing the California’s budget fluctuations. This act represented a major shift of authority from the state to the counties for mental health programs. The Realignment Fund was supported by a ½ cent increase in state sales tax, and California’s state vehicle licensing fees (NAMI California, 2010). From the very
beginning, revenues fell short of the expectations due to the recession in the 1990’s (Gardner, 1994).

Realignment funding provided funding for all community-based mental health services, state hospital services for civil commitments, and Institutions for Mental Disease, which provided long-term nursing facility care (AB 8, 1991). In 1996, Realignment funding was expanded to cover In-Home Supportive Services and Foster Care (AB 1288, 1996). This increased stress on a previously weakened funding system and has made it difficult for the fund to keep pace with mental health needs and services (Ryan, 2007). In order to further support the Realignment Fund, Federal Medicaid funding was added to supplement the shortfall (Department of Finance, State of California website, 2010).

Federal Medicaid dollars constitute the second largest revenue source for county mental health services (Rowland, Garfield, & Elias, 2010). In 1971, counties agreed to take on responsibility for managing mental health services that the federal government requires the state to provide (California Mental Health Director’s Association website, 2006). This agreement also released federal funds to counties, so that providers were able to provide more services to a larger target population. In 1993, a Medicaid State Plan Amendment added more services under the ‘Rehab Option’ to the scope of benefits, including psychiatric health facilities, adult residential treatment, crisis residential programs, crisis intervention and stabilization, intensive day treatment, day rehabilitation, linkage and brokerage, mental health services, and medication support (California
Department of Mental Health, 2010). The Rehab Option allowed services that reduce de-institutionalization and help persons with mental illness live and work in the community (Proposition 63, 2004). Beginning in 1995, a major shift in county obligations occurred with regard to Medi-Cal. The state decided to consolidate all the programs into one program, specifically for mental health services (Office of State Audits and Evaluations, Department of Finance, 2002). This program operates under a federal Freedom of Choice Waiver, and each person served has a Mental Health Plan, which creates a contract between the federal government and the Department of Mental Health to provide medically-necessary specialty mental health services to the beneficiaries of the county (Medicaid FOC, 2001). General mental health care needs for Medi-Cal beneficiaries remain under the responsibility of the Department of Health Services, and the DHS also provides for medication for the beneficiaries (California Department of Health Care Services website, 2007). Originally, it was predicted the Mental Health Plans would receive additional funds yearly beyond the base allocation for increases in Medi-Cal beneficiary caseloads, and for Cost of Living Allowances (COLA) (Social Security Online website, n.d.). Any costs beyond that were to come from Realignment Fund revenues. As of 2007, participating counties have not received COLA’s for the MediCal program since 2000 (Department of Finance, State of California website, 2010). In the FY 2003/2004 state budget, the Medi-Cal allocation to counties was reduced by 5% ($11 million SGF) (NAMI California, 2010).
A third source of funding, called Early and Periodic Screening, Diagnosis and Treatment (EPSDT) was enacted as a result of a lawsuit against the State of California in 1995 (U.S. Department of Health and Human Services, Health Resources and Services Administration, n.d.). Medi-Cal services were then expanded to beneficiaries less than 21 years of age who need specialty mental health services, whether or not such services are covered under the Medicaid State Plan. This funding stream provided funding for therapy and other services for children in need. Unfortunately, the EPSDT funds were also compensated by Realignment funds. This presented yet another stressor on the Realignment system, the original funding source for mental health services in California.

The fourth funding source was made available through federal education laws (Center on Budget and Policy Priorities, 2010). The federal Individuals with Disabilities Education Act (IDEA) entitles all children with disabilities to a free, appropriate public education (FAPE) that prepares them for the future (U.S. Department of Education website, 2010). IDEA includes mental health treatment for children and adolescents who are under 22 (California Mental Health Director’s Association website, 2006), have an emotional disturbance, and are in need of mental health services in order to benefit from FAPE. Children and adolescents can receive these services irrespective of income. Funding from this stream allows County Mental Health to link with School Districts to determine appropriate services and placement for children under the protection of their individualized education plans (IEP) and Emotional Disturbance (ED) designation. Under this funding stream, thousands of children and young adults receive services for Attention
Deficit Hyperactivity Disorder, various behavioral disorders, and other mental health issues (U.S. Department of Education website, 2010). Those services may include case management, assessment, therapy and medication support. For FY 2010/2011, the state budget calls for suspending AB 3632 (California Mental Health Director’s Association website, 2006). The Legislative Analyst’s Office sees this cut as unacceptable and detrimental to meeting the needs of children protected under IDEA.

The combination of these four funding sources, and their inherent issues, has created a challenge in ensuring funding to those afflicted with mental illness, both adults and children alike. As of 2007, the State of California owed its counties $300 million in mandate reimbursement for this program alone. In most counties, the only revenue source available to pay for these services is Realignment revenues, which are meant only for their own target population, not additional populations, such as Special Education students.

In review of Realignment, EPSDT, MHSA, and AB 3632 funding over the past 5 years, it is evident that the FY2009/2010 has been the most devastating year thus far.

Current Facts and Figures

The funding for mental health programs in the past 5 years has been all but depleted. In 2009, Governor Arnold Schwarzenegger and the State Legislators approved major eliminations. When signing the State budget, the Governor also included an almost $400 million cut to health and human services as a whole (Department of Finance, State
of California website, 2010). The final 2009-2010 budget carved more than $2 billion from California’s health care system (Health Access Organization website, 2010).

To try and measure the real impact of the mental health cuts on human life, Craft, Odeh, and Wright (2010) recall an interview with Feather River Tribal Health Clinic Director Maria Hunseker. Within the text of the interview is the retelling of a story about the eventual fallout of eliminating necessary services, including imminent danger to a California woman who had been utilizing a Northern California mental health program. The authors note this situation in an effort to highlight how very dangerous the elimination of funding to services can be – resulting in harm or even death.

In terms of the massive California state budget, the specific programs that provide services to people with HIV/AIDS and mental health may be small, but they are regarded as literal lifelines to those who depend on them. The cuts also create additional stress for surrounding community systems. Additional services (medical hospitals and the criminal justice system) normally provide balance to mental health care in normal budgetary circumstances. As a result of the budget changes, individuals that were receiving services from those mental health programs are now being ‘served’ by the criminal justice system and hospital emergency rooms. These systems are not equipped, either financially or by training, to serve the mentally ill. The systematic breakdown of the mental health system has created more stress for recipients. The Southern California Suicide Hotline, run by the Didi Hirsh Community Mental Health Center, “saw a 60% increase in calls in 2008,
and another 50% increase in callers in 2009” (LA Times, 2009). As funding sources continued to dwindle in the face of economic adversity, California voters responded.

The most recent legislation, which was passed by California voters, was the Mental Health Services Act (MHSA/Prop 63) passed in 2004. The proposition stated that 1% would be allocated from all California residents whose incomes are over $1 million (Proposition 63, 2004). When MHSA funding was distributed, it was to constitute about a 10-15% increase in overall mental health funding. Unfortunately, if the 2010/2011 state budget passes as Governor Schwarzenegger proposes, the revenue that MHSA has brought to the budget will be forced to compensate for drastic cuts in other areas of mental health funding. This proposed compensation would essentially overwhelm the fund, and additional eliminations would need to occur within that fund in order to include it in the budget. MHSA funding is expected to decline to approximately 50% of its original annual fund levels over the next 2-4 years (County of Plumas website, 2010).

The eliminations to the state budget also extend to the county level.

In the past 5 years, most counties in California have seen increasing eliminations in the state budget for community mental health services. A Sonoma County Agenda Summary Report that reviewed mental health funding in 2009 reported that realignment funding continues to decrease, as budgetary changes take place. Each year, the funding decreases by about 5% per year, with no indications of stabilizing or increasing. A New York Times article (2010) notes that the eliminations include state Mental Health Managed Care Programs and EPSDT funding, which puts stress on the system overall,
and other health care systems in particular.

It is a logical assumption that without mental health services in place, those affected by mental illness or crises will be forced to go to hospital emergency rooms and primary care physicians to get assistance. The mental health funding that is being eliminated from the state budget is at least matched in the rest of the health care system (Health Access Organization website, 2010). In terms of strictly psychiatric emergency care, the Sacramento Mental Health Treatment Center (SMHTC) has been the triage center in Sacramento for people facing psychiatric emergencies. According to the Sacramento Bee (2010), SMHTC has, since 1980, been budgeted to provide psychiatric care to adults within the county. In 2009, the Sacramento Board of Supervisors instructed the administrators of SMHTC to shut down the crisis center and 50 of its’ 100 beds (Disability Rights California website, 2010). In addition, the Department of Health Services must eliminate millions of dollars in funding, including four contracts with private agencies for Regional Support Teams that serve 8,000 adults with severe mental illness. As of September 2010, a court injunction has prevented the Regional Support Teams from closing (Hubert & Walsh, 2010).

Craft, Odeh and Wright (2010) discuss specific eliminations in the budget by highlighting the major cuts to nearly 3 million Californians covered by Medi-Cal. Those cuts include eliminating dental, speech therapy, hearing and vision coverage. Bit by bit, the mathematical equation becomes more complicated, as the State of California essentially borrows from one fund to compensate another. In a statewide and nationwide
recession, services like access to eyeglasses and hearing aids may seem trivial to some. But in a state that is desperate to have more people in the workforce, the absence of those services makes it difficult for people looking for work to find it. California Watch (2010), a project of the Center for Investigative Reporting, reports that the cuts are forcing Californians into hospital emergency rooms, sometimes waiting for 16 hours to get basic medical care. In addition, the nurse to patient ratio laws in California force increased waiting times (Health Access Organization website, 2010). That care is basic medical care by staff that is trained for such care. That does not take into account mentally ill people coming to emergency rooms for specialized services. As services of all kinds continue to change and flux at the whim of the state budget, Californians also continue to need those services. The budget for FY 2010/2011 will prove to be a pivotal one for the people of the state.

The time period for this study is from 2005-2010. As of November 30, 2010, the budget for FY 2010/2011 has yet to be passed, and it is more than 100 days past the deadline (Western Center on Law and Poverty website, 2010).

Not only do mental health providers face systematic stress, they also face stress in the workplace; when working with clients, one another, and within their particular settings.

Mental Health Providers and Stress – A General Overview

In a report completed by the NASW Center for Workforce Study (Arrington, 2008), researchers found that social workers, especially those providing direct services,
are more likely to experience stress in their respective work environments. Mental health providers, some of whom are social workers, spend their working days providing services to people with very specific and convoluted mental health challenges. Given the increasing macro-level challenges, providers are forced to provide the same level of services with less system support and tighter budgetary confinements. The providers are usually under pressure to perform in a crisis situation, and by doing so on a day-to-day basis, they are unable to relieve their own stress.

There are many different factors that can either increase or decrease work-related stress. Bell, Dalton and Kulkami (2003) highlight several of the most prominent components. They include organizational culture, workload, work environment, education, group support, and supervision.

In terms of organizational culture, the authors state, “the values and culture of an organization set the expectations about the work” (Bell, Kulkarni, & Dalton, 2003, p. 152). When an organization doesn’t have healthy coping mechanisms built into the framework, the staff can feel overwhelmed by both the direct contact and the systems with whom they interact.

A provider’s workload can also be a stress-inducing part of working in the field. The authors suggest providers may benefit from a range of service delivery – including both direct service and advocacy (Bell et al., 2003). Current trends in the field suggest the increase in workload (and the decrease in system support) can make providers feel stuck in the role they are in – in this case, a provider of mental health services. The authors
argue that for social workers in particular, the chance to balance out micro/mezzo level work with macro level work is important, as it allows the social worker to see a balanced perspective.

In terms of a provider’s work environment, the authors see safety as the primary concern. The authors argue that if a provider doesn’t feel safe in the work environment, they are more likely to be exposed to increased stress, and eventual burnout. Bell, Dalton and Kulkami (2003) feel that safety for the employees providing services should be the priority for any agency.

In a recent study, the purpose was to determine whether social workers in a child protection agency needed a stress de-briefing program in order to address work related stress. She notes that “out of 210 licensed clinical social workers, 57% had been threatened by a client or member of a client’s family, and 16.6% had been physically or sexually assaulted by a client or a member of a client’s family” (Spalding, n.d., p. 7). Any worker, in any field, would feel increased stress under these types of circumstances.

Bell, Dalton and Kulkami (2003) further discuss how a provider’s educational level can affect how they respond to stress. They found that social workers with master’s degrees had lower levels of secondary traumatic stress compared with those with baccalaureate degrees. The authors suggests that the academic framework included in a Master’s Degree program provides students with tools to better manage work related stress, including information about self-care and client empowerment. If the staff isn’t
adequately trained (or educated) they are more likely to be stressed, and even experience vicarious trauma as a result.

The importance of group support is also highlighted in various references. Horwitz (1998) feels that providers find it helpful to have opportunities to discuss their traumatic experiences with supervisors and staff, and that the assistance they receive could also be with documenting and help with other duties. Bell, Dalton and Kulkami (2003) offer mental health providers can feel more connected to one another if given the opportunity to celebrate holidays, birthdays, and take part in team building exercises and agency sponsored events. Providers that are able to share their experiences in an open and meaningful way may help to decrease stress, and provide services in a more balanced and ethical manner.

Another factor that Bell, Dalton and Kulkami (2003) discuss is supervision. They note that effective, supportive and well-trained supervisors are essential in providing a structure for social workers to express themselves in regards to their work in the field. Supervision, even for providers that are not operating at a Master’s Level or above, can provide a forum for a provider to discuss his or her concerns with someone who understands the work, and is able to sympathize effectively.

If a mental health provider feels unsupported, overworked and unappreciated, it can be assumed that there would be an increased chance of a provider feeling burnout. Burnout can affect service provision and the provider’s ability to recognize their own limitations when providing those services.
The concept of Burnout and its Implications

One of the dangers of repeated work-related stress for providers is the possibility of provider burnout. H.J. Freudenberger is credited as the father of the ‘burnout’ concept (Freudenberger, 2010). The previous meaning of burnout in the 1960’s was used to reflect repeated drug abuse (United States Office of National Drug Control Policy website, 2005). In the 1970’s, he changed the meaning of the word to reflect what he believed was the psychological state of the people that worked in the alternative health care agencies in the 1970’s. There has been research (Evans et al., 2006) about the main factors related to burnout, and two main tests given to determine a worker’s susceptibility to burnout. They include the Maslach Burnout Inventory (Jackson & Malsach, 1996) and the Pines Tedium Scale (Roberts, 1997). The Maslach Burnout Inventory (MBI) is divided into three subscales: emotional exhaustion, depersonalization and personal accomplishment. This test includes open-ended questions, and each subscale is scored separately. The Pines Tedium Scale measures 21 different experiences. This scale measures physical, emotional and mental exhaustion. The answers then indicate the main score of burnout for all items (Soderfeldt, 1995).

Previous experiments done on the issue of burnout have revealed that there are three main reasons why mental health providers feel frustrated. Lewandowski (2003) recognizes them as the labor process, the private and public issues social workers face on a daily basis, and the restraints that the work can provide, including paperwork and organizational barriers. In addition, some research suggests that personality traits can
signify whether a person is heading towards having burnout (Cherniss, 1980) (Zellars & Perrewe, 2001). The personality traits that have been attributed to burnout have included the inability to separate oneself from the work once the provider returns home, neuroticism, and “existential frustration” (Buhler and Land, 2003). “Existential frustration” is the idea that a person experiences a general sense of apathy, boredom and emptiness; this person also lacks direction, and questions the point of the activities of their lives (Frankl, 1959). Another part of the research has revealed that there really is no clear indicator of who is more likely to experience burnout.

Jones (2001) wrote a real-life account of the experiences of a group of providers which led him to comment about their experiences of social work as a

“….traumatized, even defeated occupation…the manifestations of stress and unhappiness in…social services departments were various, serious and pervasive. Social workers talked of how commonplace it was to see colleagues in tears…with social workers…walking out…of people locking themselves into their rooms or just disappearing from the office for hours on end. Going sick for some time each week or month seemed routinized in many agencies. A large number of the long serving fieldworkers had recurring and serious health problems with resulted in extended periods of absence. Many spoke of being emotionally and physically exhausted by the demands of their work” (Jones, 2001).
**Recent Studies**

It seems as if the public at large never hears stories like this one, where providers are literally beaten down by the work, and reduced to tears, absence and illness. In 2004, Coffey et al. completed a study carried out in two social service departments in the north-west of England. The aim of the study was to explore work-related stress, using a ‘problem diagnosis tool’ to understand the stressors experienced by staff, and to inform the development of interventions aimed at reducing and/or eliminating the stressors. The sample size was 1,234, and the respondents completed a questionnaire including a variety of measures to assess potential stressors and mental health. The results of the study suggested that mental well-being was poorer than previous studies have indicated, job satisfaction was lower, and organizational constraints were higher, suggesting that the situation in social services was worse than previously thought. Coping is coupled with stress, whether the mechanism be positive or negative. There have been a few notable studies that have detailed how mental health workers have responded to work related stress. The interrelated nature of stress and coping provides more information about how providers are coping with stress on a daily basis.

**Stress and Coping**

Stress has long been associated with the provision of mental health services, and there are many different types of both healthy and unhealthy coping mechanisms. Coping can involve positive restructuring, which is re-interpreting stressful situations more positively – a type of emotion-focused coping aimed at managing distress emotions,
rather than dealing with the stressor itself (Snyder, 1999). One author notes that providers often make comparisons to people whom are struggling more in life than they are, work to change perspectives on the services they provide, and utilizing appropriately timed humor to cope (Collins, 2008). Research also suggests that providers tend to utilize unhelpful coping strategies to deal with stress as well (Braaten, 2000 & Collins, 2008). Some of the most common, which will be discussed later, include drinking alcohol excessively, over or under eating, drug use, wishful thinking, day dreaming and sleeping at inappropriate times (Pearlin & Schooler, 1978). Denial is seen as a controversial coping mechanism. Some researchers argue that denial is a way for the body and mind to protect itself, while others argue that it is a roadblock to accepting what is true and processing through it in a healthy manner. In general, denial would “seem to be a negative form of coping – an opposite to acceptance – at it tends to involve a refusal to believe that a stressor exists and in a person trying to act as if the stressor is not real” (Carver et al., 1989, p. 26). Some providers may want to believe that the work isn’t stressful, in order to attempt to cope with the fact that it most likely is.

**Providers and Coping**

There has yet to be much direct research on how mental health providers, specifically, cope with work related stress, although a fair amount has been done on providers and stress (Arrington, 2008). In a study by Um and Harrison (1998), the researchers found that coping strategies had a significant impact on clinical social workers’ job satisfaction; the more often control coping strategies were used, the less job
dissatisfaction was evident. In a study done by Satymurti (1981), social workers “most commonly put their stress into perspective by reappraisal and using a positive coping strategy of ‘it could happen to anyone’ and ‘it’s not just me’, but some also disengaged mentally and behaviorally and diverted attention elsewhere, by taking time off work or even resigning”. Satymurti (1981, p. 286) also notes that the most prevalent coping strategy used was defensive disengaging, depersonalizing distancing, which led to workers stereotyping the people they served as helpless, immature and difficult. Clearly, this is a negative and unhelpful approach to coping with work related stress.

In terms of coping strategies, Stanton et al. (2000) and Soderstrom et al. (2000) found major differences in coping strategies between men and women. According to the authors, women tended to focus more on venting feelings and emotions to a far greater extent than did men. Men focused more on autonomy, minimizing vulnerability and making more use of aggressive, negative coping strategies such as drugs and alcohol. Collins (2008) also focuses on the importance of social support as a way to cope with stress. He points out that providers should be fully supported by their immediate support (spouse/partner), so as to alleviate or at least help support the weight of the work. In a study completed by Huxley et al. (2005) of mental health social workers, the authors suggested that women making better use of resources might account for their lower levels of stress. It seems as if the literature suggests that the more opportunities for a provider to express himself about the experiences they are having in the field, the better they are able to cope with the challenges it presents. The most recent study completed by the National
Association of Social Workers in 2008 provides even more detail about how providers cope with stress (Arrington, 2008). This study contains some of the most up-to-date data about this topic, and discusses how social workers have responded to work-related stress.

Facts and Figures from a Recent Study

In a study completed by the National Association of Social Workers Center for Workforce Studies, 3,653 participants were surveyed about their ability to cope with stress, and their strategies to do so (Arrington, 2008). Study participants (n=3,653) reported that the lack of time caused them the most stress in the workplace (31%), while twenty-five percent of the participants stated that their workloads had an effect on their stress levels (Arrington, 2008). Of those participants who indicated that they do not have adequate time to complete work-related tasks, 32 percent are employed in mental health settings. Social workers providing mental health services had the highest percentages related to stress resulting from working with challenging clients and from being underpaid.

In terms of stress-related health concerns, social workers that provided direct services most often cited fatigue, psychological problems, and sleep disorders as the most commonly reported stress-related health concerns (Arrington, 2008). In the study, Arrington found that thirty-eight percent of those surveyed cited a connection between psychological problems and stress-related concerns (Arrington, 2008). In the study, twelve health concerns are listed as those most concerning to social workers. They include workplace injury, decrease in work performance, irritability/aggression, impaired
immune functions, psychosomatic complaints, sleep disorders, fatigue, impaired
cognition, psychological disorders, musculoskeletal disorders, heart palpitations, and
cardiovascular problems (Arrington, 2008). Of those twelve, fatigue far outranked all the
others in frequency at 68% for women and 58% for men.

The study not only indicated what problems arose from work-related stress, it
surveyed the participants about their coping strategies. Arrington (2008) notes that
physical exercise is the most common coping mechanism. Seventy-two percent of social
workers in mental health acknowledged that exercising helps to reduce stress. Following
closely behind are meditation and therapy.

It seems that this particular study is the most comprehensive to date regarding
how work-related stress affects social workers, and the strategies they use to cope with it.

In a review of past and current literature, it seems feasible that there could be an
association between provider stress and recent, drastic changes in the California state
budget. Perhaps if legislators and upper management in county mental health had a more
comprehensive concept of what providers face, and how it may change based on
systematic distress, more support could be provided to mitigate those changes and ease
the effects.
Chapter 3

METHODS

The purpose of this study is to gauge and analyze the experiences of mental health providers in Northern California as the state is faced with budget deficits. Mental health providers are faced with both direct service and systematic changes on a daily basis, and would likely be affected by budgetary issues when working within the state system. This chapter identifies and explains the research question, study design, data gathering methods, and study population. Also identified are the limitations of this study and protection of human subjects.

Research Question

What is the Impact of 2005-2010 California State Budget Cuts on Mental Health Providers in Northern California? Is there an association between state budget cuts and increased stress for mental health providers in Northern California?

Study Design and Study Population

This was an exploratory study attempting to investigate how mental health providers are responding both personally and professionally to budget eliminations in the State of California. This study was in response to devastating budget eliminations to mental health services in California, and aimed to gather information from providers across settings and counties in Northern California.

The subjects of this research were Northern California mental health providers in the mental health system, in both public and private settings. The researcher recruited
participants by utilizing professional contacts that meet the criterion for inclusion. There were 30 people from 5-7 different providing agencies across treatment settings (Non-profit, For-Profit, private practice, school settings). The criteria for inclusion included current employment providing mental health services, age 18 or over, and participants must reside in Northern California. Criteria for exclusion included current unemployment in mental health, employment in mental health outside the time period to be studied, and those providing mental health services in other parts of the state. The researcher made contact with the providers utilizing professional contacts working within the mental health system. Each provider had the option to opt out of participating in the study.

Data Collection

The surveys was administered at the site of employment with the permission of the management. Availability sampling (providers that were available on the dates the study was completed) was used in the study, as the investigative unit was surveyed. The surveys were in blank manila envelopes, and collected separately from the Informed Consent form, in an effort to ensure the highest level of confidentiality possible. The surveys were administered in a room with a closed door, and the researcher was not present in the room with the participant following the explanation of the survey. The survey did not take more than 30 minutes to complete. The surveys were collected and stored in a lockbox in the researcher’s home. The data was analyzed by comparing the responses of the open ended questions.
**Instrument**

The researcher will be utilizing a 30-question survey in order to gather the data. The survey is structured, and includes open and closed-ended questions regarding the personal, physical and professional responses to increased stress in the mental health field from a provider’s standpoint. The content of the questions include prompts regarding service delivery, personal responses to increased stress (health and mental health), and feelings around the increased stress.

**Measurement**

The data for this study was analyzed through two different methods; content analysis and statistical analysis. The data was divided according to specific units of analysis which included demographic questions, patterns, focus and direction of questions.

**Data Analysis**

Included in the survey were both open-ended and closed-ended questions. The qualitative questions were introduced in the first half of the survey, while the demographic questions were at the end of the survey. The findings of the study was reported in aggregate form. SPSS was utilized to analyze the qualitative data produced through the closed-ended questions.

**Protection of Human Subjects**

The California State University requirement for the protection of human subjects was utilized in the formation of this study. The request for review by the CSUS
Committee for the Protection of Human Subjects was submitted to the Division of Social Work/Human Subject review committee and was approved on October 25, 2010. Recommendations included adjusting four of the questions to reduce risk within the study. Informed consent was obtained through a consent form prior to collecting any data from professional contacts of the researcher. The researcher was present to answer any questions when the participants reviewed and signed the consent form. Voluntary participation was stressed, and participants were over the age of 18 and parental consent was not needed.
Chapter 4

RESULTS

Introduction of Study

The qualitative, exploratory study consisted of descriptive research with the use of thirty surveys. The subjects were male and female, and ranged from new employees to veteran employees currently employed in mental health in Northern California. The surveys were administered at the site of employment with the permission of the management. Availability sampling (providers that are available on the dates the study will be completed) were be used in the study, as the investigative unit was surveyed. The researcher studied how mental health providers have responded professionally to recent budget cuts during the time period of 2005-2010. The data was analyzed by comparing the responses of the open ended questions, as well as responses to closed-ended questions. The findings from this data illustrated the variance of responses by mental health providers.

Demographic Data

In terms of the demographic data, it reflected that most of the providers had completed higher education levels. Of the thirty providers surveyed, over sixty-three percent of the respondents held Master’s Degrees, thirty percent held Bachelor’s Degrees, over three percent held only a high school diploma. In addition, over three percent held a degree higher than a Master’s Degree (in this particular instance, a Doctorate).
Table 1

*Level of Education of Respondents*

<table>
<thead>
<tr>
<th>Valid</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>High school diploma</td>
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<td>3.3</td>
<td>3.3</td>
<td>3.3</td>
</tr>
<tr>
<td>Bachelor's Degree</td>
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<tr>
<td>Master's Degree</td>
<td>19</td>
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<td>63.3</td>
<td>96.7</td>
</tr>
<tr>
<td>Other</td>
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<td>3.3</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

**Provider Work Settings**

The providers that participated in the study tended to reflect that sixty percent of the providers were employed through Non-Profit agencies and three percent were employed in Private Practice. In addition, over twenty-six percent were employed through County Contracted Agencies, and ten percent responded as being employed in other areas of mental health.

Table 2

*Work Setting for Respondents*

<table>
<thead>
<tr>
<th>Valid</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
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<td>Private practice</td>
<td>1</td>
<td>3.3</td>
<td>3.3</td>
<td>3.3</td>
</tr>
<tr>
<td>Non-Profit</td>
<td>18</td>
<td>60.0</td>
<td>60.0</td>
<td>63.3</td>
</tr>
<tr>
<td>County Contracted Agency</td>
<td>8</td>
<td>26.7</td>
<td>26.7</td>
<td>90.0</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>10.0</td>
<td>10.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>
**Income Level**

The respondents reported a variance in income levels. Ten percent reported an income level between fifteen thousand and thirty thousand dollars a year, and thirty percent reported an income level between thirty thousand and forty-five thousand dollars a year. In addition, twenty percent reported an income level between forty-five and sixty thousand dollars a year, thirty percent reported an income level between sixty and seventy-five thousand dollars a year, and just over three percent reported an income level of over seventy-five thousand dollars a year. Finally, almost seven percent did not report income.

Table 3

*Income Level for Respondents*

<table>
<thead>
<tr>
<th>Income Level</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$15000-$30000</td>
<td>3</td>
<td>10.0</td>
<td>10.0</td>
<td>10.0</td>
</tr>
<tr>
<td>$30000-$45000</td>
<td>9</td>
<td>30.0</td>
<td>30.0</td>
<td>40.0</td>
</tr>
<tr>
<td>$45000-$60000</td>
<td>6</td>
<td>20.0</td>
<td>20.0</td>
<td>60.0</td>
</tr>
<tr>
<td>$60000-$75000</td>
<td>9</td>
<td>30.0</td>
<td>30.0</td>
<td>90.0</td>
</tr>
<tr>
<td>Higher than $75000</td>
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<td>3.3</td>
<td>3.3</td>
<td>93.3</td>
</tr>
<tr>
<td>Missing</td>
<td>2</td>
<td>6.7</td>
<td>6.7</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

**Gender**

There are several other aspects of the data that were reflected as expected, including gender, as over sixty-six percent of the respondents were female while over thirty-three percent of the respondents were male.
Table 4

Gender of Respondents

<table>
<thead>
<tr>
<th>Valid</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>10</td>
<td>33.3</td>
<td>33.3</td>
<td>33.3</td>
</tr>
<tr>
<td>Female</td>
<td>20</td>
<td>66.7</td>
<td>66.7</td>
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<tr>
<td>Total</td>
<td>30</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

Ethnicity

In terms of ethnicity, the data was fairly representative of providers in the mental health field. Over six percent of respondents were African American, over three percent of the respondents were Asian, seventy percent of the respondents were Caucasian, ten percent of the respondents were Latino/Hispanic, and ten percent reported that they did not identify with any of the other categories.

Table 5

Ethnicity of Respondents

<table>
<thead>
<tr>
<th>Valid</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>African-American</td>
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<td>6.7</td>
<td>6.7</td>
</tr>
<tr>
<td>Asian</td>
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<tr>
<td>Caucasian</td>
<td>21</td>
<td>70.0</td>
<td>70.0</td>
<td>80.0</td>
</tr>
<tr>
<td>Latino/Hispanic</td>
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</tr>
<tr>
<td>Other</td>
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<td>10.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>
**Age**

In regards to age, almost sixty four percent of the respondents were between the ages of 28 and 42, just over nine percent of respondents are between the ages of 25 and 28, and over thirty percent of the respondents are between the ages of 44 and 67. The mean age is 39 years, 1 month, the median age is 36, and the mode age is 28.

**Table 6**

*Age of Respondents*

<table>
<thead>
<tr>
<th>Age (Years)</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
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<td>6.7</td>
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<td>6.7</td>
<td>6.7</td>
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<tr>
<td>Total</td>
<td>30</td>
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<td></td>
</tr>
</tbody>
</table>
Findings Regarding Provider Stress

The data seems to support the hypothesis of the study. Over seventy-six percent of the respondents reported an increased level of stress as a result of the budget cuts. In contrast, over twenty-three percent did not report an increase in level of stress.

Table 7

*Increased Stress for Respondents as a result of Budget Cuts*

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>23</td>
<td>76.7</td>
<td>76.7</td>
<td>76.7</td>
</tr>
<tr>
<td>No</td>
<td>7</td>
<td>23.3</td>
<td>23.3</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

However, only forty percent of the respondents reported that the level of stress on their family life had increased. Sixty percent of respondents reported that they had not experienced increased stress on their family life.

Table 8

*Increased Level of Stress on Family Life for Respondents*

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>12</td>
<td>40.0</td>
<td>40.0</td>
<td>40.0</td>
</tr>
<tr>
<td>No</td>
<td>18</td>
<td>60.0</td>
<td>60.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>
Caseload Size

A portion of the data includes information about caseload size. The data suggests that over sixteen percent of respondents reported an increase of 4-7 cases, just over twenty-three percent of providers had an increase in their caseload of 1-3 cases, while almost seventeen percent of the respondents reported an increase of more than 10 cases. Surprisingly, almost seventeen percent of the respondents also reported that their caseload did not increase at all.

Table 9

*Increase of Caseload Size for Respondents*

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not at all</td>
<td>5</td>
<td>16.7</td>
<td>16.7</td>
<td>16.7</td>
</tr>
<tr>
<td>1-3 Cases</td>
<td>7</td>
<td>23.3</td>
<td>23.3</td>
<td>40.0</td>
</tr>
<tr>
<td>4-7 Cases</td>
<td>5</td>
<td>16.7</td>
<td>16.7</td>
<td>56.7</td>
</tr>
<tr>
<td>8-10 Cases</td>
<td>4</td>
<td>13.3</td>
<td>13.3</td>
<td>70.0</td>
</tr>
<tr>
<td>More than 10</td>
<td>5</td>
<td>16.7</td>
<td>16.7</td>
<td>86.7</td>
</tr>
<tr>
<td>None, no caseload</td>
<td>4</td>
<td>13.3</td>
<td>13.3</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

Service Delivery

The data also reflected the level of changes in service delivery. Over thirteen percent of respondents reported no change in service delivery. Over fifty-six percent of the respondents stated that their service delivery had changed moderately as a result of
the budget cuts, while almost twenty-seven percent reported that their service delivery had changed severely as a result of the budget cuts.

Table 10

*Level of Changes in Service Delivery for Respondents*

<table>
<thead>
<tr>
<th>Valid</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>4</td>
<td>13.3</td>
<td>13.3</td>
<td>13.3</td>
</tr>
<tr>
<td>Moderately</td>
<td>17</td>
<td>56.7</td>
<td>56.7</td>
<td>70.0</td>
</tr>
<tr>
<td>Severely</td>
<td>8</td>
<td>26.7</td>
<td>26.7</td>
<td>96.7</td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>3.3</td>
<td>3.3</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

**Physical Complaints**

The respondents also reported physical complaints as a result of increased stress on the job. The most common complaints were headaches and fatigue. Also reported were symptoms such as muscle tension and weakness. Of those providers surveyed, fifty percent reported that they had knowledge of other providers having headaches as a result of increased stress in the workplace.

Table 11

*Knowledge of Headaches for Respondents*

<table>
<thead>
<tr>
<th>Valid</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>15</td>
<td>50.0</td>
<td>50.0</td>
<td>50.0</td>
</tr>
<tr>
<td>No</td>
<td>15</td>
<td>50.0</td>
<td>50.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>
Fatigue

As for fatigue, over seventy-three percent of the respondents reported that they had knowledge of a provider who had experienced fatigue as a result of budget cuts. In contrast, almost twenty-eight percent of respondents reported that they had no knowledge of providers who had experienced increased fatigue as a result of the budget cuts.

Table 12

*Level of Fatigue for Respondents*

<table>
<thead>
<tr>
<th>Valid</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>22</td>
<td>73.3</td>
<td>73.3</td>
<td>73.3</td>
</tr>
<tr>
<td>No</td>
<td>8</td>
<td>26.7</td>
<td>26.7</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

Job Security

In terms of job security, one hundred percent of the respondents reported that they are worried about retaining their current positions in the mental health field.

Table 13

*Job Security Concerns for Respondents*

<table>
<thead>
<tr>
<th>Valid</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>30</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Mental Health Services

Regarding providers receiving mental health services, exactly fifty percent of respondents reported that they had knowledge of providers receiving mental health services as a result of increased stress due to budget cuts. The remaining fifty percent reported that they had no knowledge of providers receiving mental health services as a result of increased stress due to budget cuts. Medication utilization was also reported in the study.

Table 14

*Knowledge of Providers Receiving Mental Health Services*

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>15</td>
<td>50.0</td>
<td>50.0</td>
<td>50.0</td>
</tr>
<tr>
<td>No</td>
<td>15</td>
<td>50.0</td>
<td>50.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

Medications

In addition to mental health services, over forty-three percent of respondents reported having knowledge of providers utilizing over-the-counter or prescription medications as a result of increased work-related stress, and over fifty-three percent reported no knowledge of providers utilizing over-the-counter or prescription medications as a result of increased work-related stress.
Table 15

Knowledge of Utilization of Over the Counter or Prescription Medications

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>13</td>
<td>43.3</td>
<td>43.3</td>
<td>43.3</td>
</tr>
<tr>
<td>No</td>
<td>16</td>
<td>53.3</td>
<td>53.3</td>
<td>96.7</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>3.3</td>
<td>3.3</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

Feelings

The data also reflected providers’ feelings regarding increased stress due to budget cuts. Over seventy-three percent of respondents reported being saddened or angered by recent changes in their agency as a result of increased stress, while almost twenty-seven percent of respondents responded that they did not report being saddened or angered by recent changes in their agency as a result of increased stress.

Table 16

Feelings regarding Budget Cuts and Stress for Respondents

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>22</td>
<td>73.3</td>
<td>73.3</td>
<td>73.3</td>
</tr>
<tr>
<td>No</td>
<td>8</td>
<td>26.7</td>
<td>26.7</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>
Associations between Variables

The data was also analyzed to identify any relationships that exist between the variables. The level of stress for providers was compared to two different variables; increased levels of stress on the family life, and providers experiencing headaches.

Table 17

*Relationship between Individual Stress and Family Stress for Providers*

<table>
<thead>
<tr>
<th></th>
<th>Value</th>
<th>df</th>
<th>Asymp. Sig. (2-sided)</th>
<th>Exact Sig. (2-sided)</th>
<th>Exact Sig. (1-sided)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearson Chi-Square</td>
<td>6.087a</td>
<td>1</td>
<td>.014</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continuity Correctionb</td>
<td>4.107</td>
<td>1</td>
<td>.043</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Likelihood Ratio</td>
<td>8.539</td>
<td>1</td>
<td>.003</td>
<td>.024</td>
<td>0.16</td>
</tr>
<tr>
<td>Fisher's Exact Test</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N of Valid Cases</td>
<td>30</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a. 2 cells (50.0%) have expected count less than 5. The minimum expected count is 2.80.
b. Computed only for a 2x2 table

In examining the possible relationship between increased levels of stress for providers and the level of stress on the family life of the provider, the data reflected that we reject the null hypothesis of no association and conclude there is likely an association.

In this particular part of the study, the data reflected that there was a correlation between feeling increased levels of family and individual stress, and increased stress having an effect on their family lives.

Summary of Findings

As the nation, the state, and counties within California continue to face budget shortfalls, the elimination and reorganization of financial resources places significant
stress on services offered to those in need. Mental health providers (and the agencies in which they practice) are largely funded through federal, state and county monies, and when the financial resources are lessened, providers are forced to provide services under different circumstances. From 2005-2010, counties in Northern California have seen major cutbacks in resources for mental health, and subsequently, providers have been put under additional stress in the provision of those services. The qualitative, exploratory study consisted of descriptive research which summarized findings from thirty surveys.

Through analysis of the data, the respondents provided new information regarding their stress and how they cope with it while providing services in the field of mental health.

**Major Themes**

Both healthy and unhealthy coping mechanisms were highlighted within the data. Providers that participated in the study reported nine activities they utilize to cope with increased stress. Healthy coping mechanisms reported include exercise, socializing, mindfulness, time with family, not working from home, massages, Tai Chi, and working on hobbies. Only one provider reported an unhealthy coping mechanism, which was isolation. Overwhelmingly, providers in the study cited physical exercise as the primary way that participating providers cope with increased work-related stress. The researcher expected to see more unhealthy coping mechanisms reported by participants in the study.
Physical Symptoms

Participants also reported an increase in physical symptoms and general exhaustion as a result of increased work-related stress. Nine participants reported taking additional sick time due to increased stress. Participants also reported that they felt an increase in overall stress. One provider reported having knowledge of a death through suicide due to increased stress. The researcher found this particular report to be significant.

Utilization of Medications

 Providers reported that they had knowledge of other providers utilizing over-the-counter and prescription medications in order to cope with increased stress. Based on the responses, eight of the medications reported are only available by prescription (Ambien, Buspar, Prozac, Xanax, Zoloft, Celexa, Lexapro, and Effexor). The other four medications are available over-the-counter (Tylenol, St. John’s Wort, Aspirin, and Ibuprofen). It should be noted that six of the prescription medications are listed as antidepressants (WebMD, n.d.).

Feelings about Budget Cuts

One of the open-ended questions included in the study was in regards to any feelings providers may have had regarding the budget cuts and the effects of the cuts on service provision. Many of the providers noted feelings of anger, sadness, frustration, a lack of patience and understanding, and betrayal by management within their agencies. One provider remarked that the sense of anger has begun to permeate through every
aspect of service provision and overall staff morale. She reported that she finds herself ‘really annoyed between sessions…try hard to put my anger and frustration away before my next client’.

**Job Security**

The most notable theme reflected in the data is concern about job security. One-hundred percent of the participants reported being worried about job security. This statistical reflection could be generalized to the population as a whole, although as of 2009, only thirty-eight percent of Americans listed job security as their number one concern (Staff, 2009). Although the researcher expected to see statistically significant data in this area, such significance was not expected.

The data analyzed in this study supports the idea that mental health providers have been adversely affected by budget cuts in from 2005-2010. It is notable that for most of the mental health providers, the effects of the budgets cuts have had an impact on their lives, both professionally and personally. The providers report changes in length and frequency of service delivery, the level of stress on them as individuals and their families, feelings of sadness and anger, and high levels of distress about job security. It could be argued that the budget cuts have placed additional distress on mental health workers, despite already working in a field that can be stressful, and the data seems to support that argument.
Chapter 5

CONCLUSIONS AND RECOMMENDATIONS

Review of Findings

This study reflects the feelings, attitudes and experiences of mental health providers in Northern California. The quantitative and qualitative findings indicate that providers are experiencing increased stress due to budget cuts, and utilizing different coping methods to handle the challenges they face.

Qualitative Findings

The open ended questions included in the study produced honest narrative about what providers are experiencing while providing services. Included in those answers were revelations about having knowledge of a provider committing suicide as a result of increased stress, and providers feeling stress about budget cuts literally while providing services. Providers also detailed how they cope with the stress, including Tai Chi, exercise and utilizing more sick and vacation days. Providers also reported that spending more time with family and friends was also beneficial.

Quantitative Findings

The closed ended questions included in the study produced data regarding how providers have been affected by recent budget cuts and the stress they felt as a result in addition to demographic data. Thirty percent of respondents reported their income between thirty and forty-five thousand dollars a year, and almost seventy percent of the respondents were female. Seventy percent of the respondents were Caucasian, and almost
sixty-four percent of the respondents were between the ages of 28 and 42. In terms of provider stress, over seventy-six percent of the respondents reported feeling increased stress as a result of the budget cuts, and sixty percent of the respondents reported an increase of the level of stress on the respondents’ family lives. There is also a relationship between providers feeling increased levels of stress and that stress affecting the family lives of the providers. Changes in caseload size are also explored, with over twenty-three respondents reporting an increase in 1-3 cases. Respondents also reported physical responses to stress, including fifty percent of the respondents reporting headaches, and over seventy-three percent of the respondents reported an increased level of fatigue. The concern about job security was particularly notable; one hundred percent of the respondents reported concerns about job security. Respondents also reported knowledge of providers receiving mental health services, and fifty percent reported that they did have that knowledge. In regards to providers’ feelings about the budget cuts and stress, over seventy-three percent of the respondents reported feeling sadness and anger.

**Implications for Social Work Practice**

For mental health workers, the challenge of providing services in the face of budgetary issues becomes increasingly more complicated. It continues to become more difficult to provide services in agencies or schools that utilize government funding. Based on the data gathered during this study, it seems as if providers don’t feel as if they have received enough support from their employers, which has made them more frustrated. It would be logical to assume that eventually, the increased stress coupled with the lack of
support from management would lead providers to have to make choices about their employment. Those choices could include changing positions or changing careers altogether. It would be detrimental to those who are in need of services to be without dedicated providers, especially due to budgetary issues that can be addressed by the voting public.

The pressures that mental health providers are operating under during these difficult economic times will no doubt affect the provision of the services. Included within the data from this study was a statement regarding feeling increased stress during service provision, even when providing direct services. The concept that a provider would be concerned about either budgetary issues or increased stress as a result while providing services is nothing short of alarming. One provider remarked that she was taking steps to address her stress while providing direct services, but the idea that stress for this provider has now entered into session is not a good indication of what other providers may be feeling. With more than seventy-six percent of the respondents reporting increased stress, it is logical to assume that the stress would be more challenging to separate from the provision of direct services. In addition, the relationship between increased stress for the provider as an individual and that stress affecting family life can make it more difficult for providers to separate themselves from their work lives, and have an adverse effect on family life. More studies in that particular area would need to be completed in order to assess any new trends.
Implications for Social Work Research

This study could very well be reflective of a larger issue among mental health providers throughout the state and the nation. Reviewing the findings from a similar study completed with a larger sample size to determine if the trend was present in other areas of the state and country. Also, reviewing the data of a newer study to see if the data from this study regarding concern about job security (with one hundred percent of the respondents reporting being concerned) was generalized over a larger sample size. In addition, research regarding provider stress could create more dialogue about using data to support providers in the field by including stress reduction activities and exercises within agency policy.

If given the opportunity to do this study over again, the researcher would have made a better attempt at diversifying the pool of participants. In the areas of the respondents’ gender and areas of employment, the data is not necessarily reflective of the field as it is. Although it was fairly simple to gather the data, the responses in these two areas were skewed. Also, the researcher would have included a question in the survey about what the providers felt would be helpful to ease the stress within their respective workplaces. This knowledge would have helped the researcher to gain some insight into possible solutions or aides for providers working in the field.

Although the researcher has been in the field of mental health for over ten years, the level of stress and anxiety was not necessarily anticipated. Specifically, the data around medication and mental health service utilization was higher than was expected.
As a current provider, it was a confirmation of what the researcher had been sensing in her own workplace; frustration, anger, annoyance, stress and sadness. In the researcher’s experience, providers spend increasing amounts of time discussing the way services ‘used to be’ and the activities providers ‘used to’ be able to take clients to enjoy. Even the clients remember services as they were, and see the changes another disappointment. Providers have been forced to become more creative in their treatment approaches, despite the decreasing resources.

**Implications for Social Work and Agency Policy**

The researcher believes that mental health agencies could benefit from this research, and make efforts to infuse stress reduction protocol into agency policy. Major associations such as the National Association of Social Workers could also utilize the data to make efforts to provide more support to providers at the macro level of practice, and provide additional resources and linkages for providers in the field of mental health. For both agencies and larger associations, doing so would be mutually beneficial – providers would have more support in managing stress, and agencies would most likely see a more productive workforce.

**Summary and Conclusion**

This study has found that there is increasing evidence to suggest that providers are under more stress due to budget cuts in Northern California. The data suggests that providers are experiencing adverse physical symptoms, having feelings of sadness and anger, and being very concerned about job security. Additional research would be
beneficial in gathering and analyzing more data in support of more resources and
linkages for agencies to help support their staff. It is the hope of the researcher that the
data gathered will bring to light the conditions that mental health providers are faced
with, and that steps will be taken to both alleviate stress and assist management in
supporting providers more adequately.
APPENDICES
APPENDIX A

The Affects of Budget Cuts on Mental Health Providers in Northern California

Mental Health Providers, California

Dear Provider,

This instrument will help measure how you (as a mental health provider) have been affected by budget cuts in the mental health field in California from 2005-2010. All data will remain confidential and results will be reported anonymously.

1. In what areas have you noticed change in your life as a result of recent budget cuts? (Please circle all that apply)

A. Level of income
B. Level of stress
C. Number of hours worked
D. Level of stress on family life
E. None
F. Other

2. If you carry a caseload, has your caseload increased as a result of budget cuts? If so, by how much?

A. Not at all
B. 1-3 cases
C. 4-7 cases
D. 8-10 cases
E. More than 10
F. None, I don’t carry a caseload

3. Have the effects of the budget cuts had an impact on the length or frequency of your service delivery?

A. Not at all
B. Moderately
C. Severely
4. In your place of employment, how has the management addressed the budget cuts and its affect on the morale? (Please circle all that apply)

A. Not at all  
B. Staff meetings  
C. Email  
D. Trainings  
E. Other _____________________________

5. Have you increased your use of any coping activities (i.e., exercise, gardening, more vacations/sick time) as a result of recent budget cuts? If so, please list them below.
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

6. Do you have knowledge of any providers who have suffered adverse physical symptoms that they attribute to increased work-related stress?

A. None  
B. Headaches  
C. Weight gain/loss  
D. Muscle Strain  
E. Fatigue  
F. Other _____________________________

7. Do you have any knowledge of any providers being more worried about job security?

A. Yes  
B. No  

8. Do you have any knowledge of any providers utilizing mental health services as a direct result of work related stress?

A. Yes
B. No

9. Do you have any knowledge of any providers who have utilized any medications (over-the-counter or prescription) as a result of possible stress? If so, please list the medications below.

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________


10. Do you have any knowledge of any providers being saddened or angered by recent changes in your agency as a result of increased stress? If so, please explain

_____________________________________________________________________

_____________________________________________________________________


11. How long have you worked in mental health?

a. 0-3 years
b. 3-5 years
c. 5-8 years
d. Over 8 years

12. What is your highest level of education?

a. Less than High school diploma
b. High school diploma
c. Bachelor’s Degree
d. Master’s Degree
e. Ph.D
f. Other
13. What is your ethnicity?
   a. African-American/Black
   b. Asian
   c. Caucasian
   d. American Indian
   e. Latino/Hispanic
   f. Other

14. What is your marital status?
   a. Single
   b. Married
   c. In partnership
   d. Other

15. What is your age?
    __________________________

16. What is your gender?
   a. Male
   b. Female
   c. Transgender
   d. Other

17. Do you have any children?
   a. Yes
   b. No

18. What type of setting do you work in?
   a. Private Practice
   b. Non-Profit
   c. For Profit
   d. County Contracted Agency
19. What is your County of Employment?

   a. Sacramento
   b. Alameda
   c. Yolo
   d. Susuin
   e. Contra Costa
   f. Other ____________________

20. What is your income level?

   A. $15,000 – $30,000 annually
   B. $30,000 - $45,000 annually
   C. $45,000 - $60,000 annually
   D. $60,000 - $75,000 annually
   E. Higher than $75,000 annually
APPENDIX B

Consent to Participate in Research

You are being asked to participate in research conducted by Sara Meadows, a Graduate Student in Social Work at California State University, Sacramento. The study will investigate factors related to how mental health providers have been affected by state-wide budget cuts over the past 5 years in California.

You will be asked to respond to a questionnaire about your academic history, employment history, and your responses to work-related stress. The questionnaire may require up to 30 minutes of your time.

Some of the items in the questionnaires may seem personal, but you don’t have to answer any question if you don’t want to. You have the ability to decline any question or withdraw from the study, at any time, for any reason.

You may gain additional insight into how you have coped with recent budget cuts in your place of employment, or you may not personally benefit from participating in this research. It is hoped that the results of the study might be beneficial for program evaluators when restructuring programs due to budget cuts.
You will not receive any compensation for participating in this study.

If you have any questions about this research, you may contact Sara at (916) 230-1622 or by e-mail at smara78@gmail.com, or my Thesis Advisor Teiahsha Bankhead, PhD, LCSW at bankhead@csus.edu.

Your participation in this study is entirely voluntary. Your signature below indicates that you have read this page and agree to participate in the study.

_____________________________                            ____________________
Signature of Participant                                                      Date
REFERENCES


AB 1288, CA 57 (D. Cal. 1996).

AB 2034, CA 46 (D. Cal. 2000).

AB 8, CA 14 (D. Cal. 1991).


California Department of Mental Health. (2010). www.dmh.ca.gov

California Mental Health Director’s Association website. (2006). www.mhac.org


Mental Health Association in California website. (n.d.). http://www.mhac.org/mhservices/history.cfm


Proposition 63, CA 4 (D. Cal. 2004).


Short-Doyle Act, CA 22 (D. Cal. 1959).
http://books.google.com/books?id=z45iqgEFNYwC&printsec=frontcover&dq=coping&hl=en&ei=K3z0TKijAon0swO887ziCw&sa=X&oi=book_result&ct=result
&resnum=1&ved=0CCwQ6AEwAA#v=onepage&q&f=false


www.finance.boston.com


www.whitehousedrugpolicy.gov

WebMD. (n.d.). www.webmd.com