

NO PLACE TO TURN: Mental Health in Washington State

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Executive Summary

A Monroe man, suffering from severe depression and distraught over his family's inability to get treatment, kills himself and his grandson. A Kent woman, impaired by substance abuse and experiencing hallucinations, goes on an alcoholic binge and starves her two children to death. Fifty percent of teenagers with "emotional disorders" drop out of high school. Hundreds of children are removed from their dysfunctional families every day.

These are the stories of people who have no place to turn. They are people who have been touched by mental illnesses. They all have treatable conditions. All of these tragedies could be avoided.

Unfortunately, the mental health system we have here in Washington State is fragmented and desperately underfunded. To make matters worse, most Washingtonians do not have adequate mental health insurance, and the publicly supported safety net—which is supposed to be there for those who have no where else to turn—is spotty at best. As a result, mental health services are out of the reach for many people across the state and their mental, physical, and financial health is being put at risk.

At least 20 percent of all people—about 1.2 million people in Washington State—have a diagnosable mental illness. Only about 14 percent of those people have health insurance that covers all of their mental health care needs. This is called mental health parity—insuring coverage for mental illness in the same way physical ailments are covered. Instead, most insurance plans—covering about two-thirds of the people in the state—provide a limited amount of coverage for mental health problems, but often at a level well below what is required to fully treat a serious mental illness. The remainder have no mental health insurance, yet only seven percent of the mentally ill qualify for care under the state's mental health care safety net. This means that very few people who have a diagnosable mental disorder actually have the insurance they need to get the treatment they require.

Because many of these people cannot afford needed mental health care, their conditions typically worsen, they get sick more often, and they consume more health care resources for mental and physical problems. People with untreated mental illnesses do poorly in school and end up in prisons more often. They cost the people of this state billions of dollars through lost productivity, unemployment, disability, accidents, injuries, and criminal activity. These problems are personal tragedies for many of Washington's families.

Washington must take a stand against mental illness. Like diabetes and hypertension, most mental illnesses respond to treatment and improve with regular care management. To improve the lives of so many Washingtonians affected by mental illness, we must make treatment for mental illnesses more accessible. This will require us to: (1) Reduce the stigma surrounding mental illness that prevents many people from seeking treatment, (2) Ensure parity in health insurance for both mental illness, and (3) Adequately fund the mental health safety net so that the services people need are available when they have no place else to turn.

Mental Health in Washington State

Bryan Hetherwick, a 58 year old man who suffered from severe depression, recently reached his limits trying to access mental health services in Washington State. Having recently moved from Texas to Snohomish County, Bryan was unable to find a day treatment program for which he was eligible. Although he was on medication, he was not receiving regular, necessary therapy. To make matters worse, his adopted grandson, Brennan, also suffered from bipolar disorder, but Bryan and his wife, Carolyn, could not find an appropriate treatment program for Brennan as well. After months of trying to get help, Bryan was increasingly depressed. On August 5, 2004, Brennan was asked to leave yet another treatment program that he had attended for only one day. It was too much to take. Overwhelmed by it all, Bryan ended both his life and the life of his grandson later that day, just outside the Monroe Police Station. He left behind his wife Carolyn, who is physically disabled but does not qualify for public assistance.

Like Bryan Hetherwick, the majority of people in Washington State do not have adequate access to mental health care services. Although at least 20 percent of all people have a mental illness, only about 14 percent of Washingtonians have health insurance that adequately covers mental health treatment. In general, private health insurance does not provide sufficient coverage to enrollees for mental health problems. And for those without private insurance, mental health safety net services are limited and not even accessible to most people with mental illness. The gap between the services available to the insured and the services available via the safety net is vast and unforgiving—leaving a significant number of our family, friends, and neighbors without access to the mental health care they need.

Without affordable health insurance that adequately covers mental health services, people with mental illness suffer. Their condition worsens, they get sick more often, and they consume health care resources for mental and physical problems. They cost the people of this state billions of dollars through lost productivity, unemployment, disability, accidents, injuries, and criminal activity. These problems are personal tragedies for many of Washington's families.

Mental Illness is Common

Mental illnesses are among the most common yet least treated health problems in America today. In fact, the most current prevalence estimates suggest that about one in five people is afflicted by a diagnosable mental illness.¹ This means that in any given year, about 54 million adults across the country—and about 1.2 million people in Washington State—are affected by a diagnosable mental disorder.²

Despite the widespread prevalence of mental illness, it is estimated that two-thirds of all people with a diagnosable mental illness do not seek professional treatment.³ Untreated mental health

¹ Regier, D. A., Narrow, W. E., Rae, D. S., Manderscheid, R. W., Locke, B. Z., & Goodwin, F. K. (1993). The de facto mental and addictive disorders service system. Epidemiologic Catchment Area prospective 1-year prevalence rates of disorders and services. *Archives of General Psychiatry*, 50(2), 85-94.

² U.S. Department of Health and Human Services. (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

³ Regier, D. A., Narrow, W. E., Rae, D. S., Manderscheid, R. W., Locke, B. Z., & Goodwin, F. K. (1993). The de facto mental and addictive disorders service system. Epidemiologic Catchment Area prospective 1-year prevalence rates of disorders and services. *Archives of General Psychiatry*, 50(2), 85-94. Kessler, R. C., Nelson, C. B., McKinagle, K. A., Edlund, M. J., Frank, R. G., & Leaf, P. L. (1996). The epidemiology of co-occurring addictive and mental disorders: Implications for prevention and service utilization. *American Journal of Orthopsychiatry*, 66, 17-31.

problems lead to a diminished quality of life and prevent many people from functioning normally in our society. Mental health problems tend to worsen if they are not treated, and individuals who are afflicted by mental illness often do not return to their normal baseline after an untreated or poorly treated episode. In addition, successive poorly treated episodes can lead to deteriorating function and declining ability to work and engage in normal daily activities, often to the point that the person is considered disabled. Four of the ten leading causes of disability are mental disorders.⁴

Children suffer a similar fate. Like adults, one in five children between the ages of nine to 17 is afflicted by mental illness during a given year, and only 20 percent of these children receive any treatment.⁵ Mental illness also arises in children under the age of nine, although it is often misdiagnosed at such early ages. And also like adults, the consequences of untreated mental illness for children can be devastating. Without necessary mental health treatment, children are at risk of failing in school, social isolation, delinquency, and more serious deterioration that can result in hospitalizations and suicidal behavior. The dropout rate of students with “emotional disturbances” (the school system’s equivalent to mental health problems) is about 50 percent.⁶ Left untreated, mental health problems during childhood can lead to lifelong difficulties. Not only do these children suffer from mental health problems and the social stigma that goes along with such conditions while they are in school, but most enter the world as adults with a lower quality of life and reduced opportunities. It is estimated that at least three-quarters of adults with mental health problems had recognizable difficulties during childhood and adolescence.⁷

Numerous studies demonstrate the effectiveness of psychological and pharmacological therapies for treating mental illness in both adults and children. Depressive disorders are among the most responsive to treatment. More than four out of five people with clinical depression respond to psychotherapy, medication, or a combination of the two.⁸ Similarly, cognitive behavior therapy and self-control therapy have been demonstrated to effectively treat children with depression,

Fast Facts

- Some 8 million to 14 million Americans suffer from depression each year.
- About 12 million children under 18 suffer from mental disorders, such as autism, depression, and hyperactivity.
- Two million Americans suffer from schizophrenic disorders, and 300,000 new cases occur each year.
- About 15.4 million American adults and 4.6 million adolescents experience serious alcohol-related problems. Another 12.5 million suffer from drug abuse or dependence.
- Twenty percent of the ailments for which Americans seek a doctor’s care are related to anxiety disorders, such as panic attacks, that interfere with their ability to live normal lives.
- Nearly one-fourth of the elderly who are labeled as senile actually suffer from some form of mental illness that can be treated effectively.
- Suicide is the second leading cause of death for youth in the state.
- In 2001, mental health became the leading reason children ages 5 to 19 years old in Washington State were hospitalized.

Source: American Psychiatric Association; *The State of Washington’s Children* (2000), University of Washington School of Public Health and Community Medicine; and Washington State Department of Health.

⁴ Murray, C. J. L. & Lopez, A. D., Eds. (1996). *The global burden of disease: a comprehensive assessment of mortality and disability from diseases, injuries and risk factors in 1990 and projected to 2020*. Cambridge, MA: Harvard School of Public Health on behalf of the World Health Organization and the World Bank (Global Burden of Disease and Injury Series, Vol. I).

⁵ Regier, D. A., Narrow, W. E., Rae, D. S., Manderscheid, R. W., Locke, B. Z., & Goodwin, F. K. (1993). The de facto mental and addictive disorders service system. Epidemiologic Catchment Area prospective 1-year prevalence rates of disorders and services. *Archives of General Psychiatry*, 50(2), 85-94. Kessler, R. C., Nelson, C. B., McKinagle, K. A., Edlund, M. J., Frank, R. G., & Leaf, P. L. (1996). The epidemiology of co-occurring addictive and mental disorders: Implications for prevention and service utilization. *American Journal of Orthopsychiatry*, 66, 17-31.

⁶ Jans, L., Stoddard, S. & Kraus, L. (2004). *Chartbook on Mental Health and Disability in the United States*. An InfoUse Report. Washington, D.C.: U.S. Department of Education, National Institute on Disability and Rehabilitation Research.

⁷ University of Washington School of Public Health and Community Medicine. (2000). *The State of Washington’s Children* (SWC-2000).

⁸ Goodwin, F. K. and Jamison, K. R. (1990). *Manic-Depressive Illness*. New York: Oxford University Press.

decreasing depressive symptoms and improving social functioning, with lasting results after treatment is completed.⁹ Perhaps surprisingly, recovery rates for many mental illnesses actually surpass the treatment success rates for many physical illnesses, including heart disease. The recovery rates are impressive: the rate is estimated to be between 65 to 80 percent for major depression, about 60 percent for schizophrenia, and about 80 percent for bipolar disorder.¹⁰

Yet the majority of people who suffer from mental illness do not get treatment. Many factors contribute to this trend. One of the primary barriers to treatment is the stigma surrounding mental illness, which often discourages people from seeking help. Another major barrier is a lack of available and accessible mental health service providers. But perhaps the greatest barrier to treatment—and one of the most cost-effective problems to resolve—is insufficient health insurance for mental health services.

Accessing the System

Many people in Washington State do not have access to the mental health services they need because of inadequate health insurance. Mental health benefits under private health insurance plans are limited for most people, and the mental health safety net—which we depend on when we have limited coverage or lose our health insurance—is woefully unable to meet the mental health care needs of the state.

To our knowledge, no commercially available insurance plans in Washington State provide parity in the coverage of their mental health benefits. Instead, these plans have treatment limitations and/or greater cost-sharing requirements for mental health benefits than for medical and surgical benefits.¹¹ While most people do not ever reach their coverage limits, people who do need more treatment than their plan covers can quickly find themselves in a position where they cannot access that needed care, and they suffer long-term effects as a result. Most people are forced to forgo treatment after exceeding their benefits and are left with unresolved mental health problems.

Because of these coverage limits, many people who have exhausted their private health insurance must turn to Washington's mental health safety net—a patchwork system comprised of public and private agencies. Although public programs are available for people who have exceeded their benefits or have no health insurance, safety net services are mostly limited to people who have severe and persistent mental health problems lasting a year or more. Thus, people cannot access the safety net until their mental illness has progressed to the point where they have become destitute, are unable to maintain their job, and oftentimes have lost their housing. It is estimated that less than seven percent of people with mental health disorders in King County have access to these safety net providers.¹² And children have even more limited access. In 2002, only 2.4 percent of Washington State children received publicly funded mental

⁹ Burns, B. J., Compton, S. N., Egger, H. L. & Farmer, E. M. Z (2000). *Assessing the Impact of Childhood Interventions on Subsequent Drug Use* (NIDA Contract 263-MJ-919512). Durham, NC: Services Effectiveness Research Program.

¹⁰ Varmus, H. E. (1998). *Parity in Financing Mental Health Services: Managed Care's Effects on Cost, Access, and Quality: An Interim Report to Congress*. National Advisory Mental Health Council. Rockville, MD: National Institute of Mental Health.

¹¹ Estimates for Washington based on data provided in Maxfield, M., Achman, L. & Cook, A. (2004). *National estimates of mental health insurance benefits* (DHHS Pub. No. (SMA) 04-3872). Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

¹² Estimates for King County based on data provided in the Epidemiologic Catchment Area study (1980) and National Comorbidity Survey (1990), and data provided in the King County Regional Support Network 2003 Mental Health Plan Year End Report Card.

health services, despite the fact that more children are living in poverty in our state than are adults.¹³

Regardless of insurance status, however, people are facing significant difficulties gaining access to mental health services. The availability of mental health services in Washington State is more limited compared to most other states, in large part due to state and federal budget cuts that have limited funding to mental health providers. Shortages have been noted in the availability of community services, involuntary treatment, psychiatric beds, and community residential alternatives to hospitals. It is estimated that if Washington State invested in hospital beds at the same rate as peer states, we would have an additional 331 state beds available for treatment of mental health problems.¹⁴ At the same time, however, we must also make better use of the resources that are currently available. For example, it is estimated that on an annual basis, 520 admissions to hospitals for ‘medical’ reasons are due to inadequate community placements for mentally ill patients.¹⁵ Failure in one part of the system quickly creates significant but avoidable pressures on other parts of the system.

The Cost of Mental Illness

Lack of adequate insurance for mental health services is costing us all more. Working families affected by mental illness are being hit particularly hard by the costs of mental health treatment. Mental health expenses for people with serious illnesses are often out of the reach of middle class families. Intensive treatment or hospitalization is very costly, and coverage limits on visits and inpatient days leave families financially exposed to cover significant portions of treatment—effectively leaving care out of reach for most. Even with insurance, a family with mental health treatment expenses of \$35,000 a year has an average out-of-pocket burden of about \$12,000. For those with \$60,000 in annual mental health expenses, families spend on average \$27,000.¹⁶ These are not unusual bills for people hospitalized with mental illness. The majority of families simply cannot afford such high costs and are forced to either forgo services altogether or to risk the prospect of bankruptcy in order to continue receiving treatment.

The national direct costs for treatment of and rehabilitation from mental illness were \$69 billion in 1996.¹⁷ Indirectly, these disorders cost even more. In 1990, it was estimated that mental illness cost more than \$78 billion in lost employment, reduced productivity, criminal activity, vehicular accidents, and social welfare programs.¹⁸ In Washington State, this translates to avoidable costs totaling about \$1.5 billion annually. These numbers are estimated to be even greater today. Despite their staggering proportions, many of these costs are preventable and could be avoided with better coverage for mental health problems.

Mental Health Insurance and Parity

As discussed above, no commercial health insurers in Washington State provide parity—similar

¹³ Washington State Department of Health and Human Services. Mental Health Division. FY 2002 Medicaid enrollment data.

¹⁴ Brown, T. & Brimmer, K. (2002). *Projecting the Need for Inpatient and Residential Behavioral Health Services for Adults Served by the Mental Health Division*. Boston, MA: Public Consulting Group, Inc.

¹⁵ Ibid.

¹⁶ U.S. Department of Health and Human Services. (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

¹⁷ Ibid.

¹⁸ Ibid.

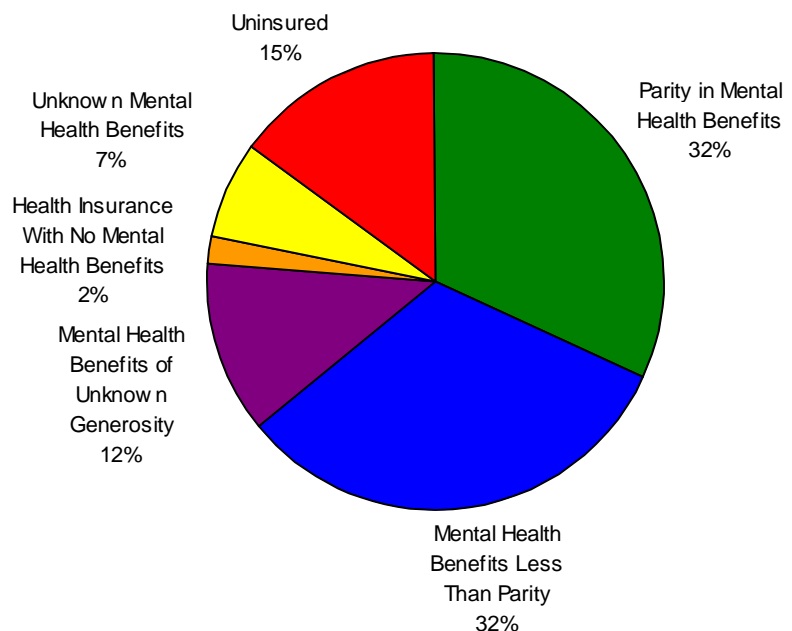
benefits for mental problems as are provided for physical problems. A limited number of employers, including the federal government and some self-insured employers, do provide benefits with mental health parity to their employees, yet it is estimated that only 14 percent of people living in Washington have parity.

Throughout the country, people fare better. More than 30 states now provide some form of parity, and as shown in Figure 1, about one-third of all people nationally have equal mental health benefits.¹⁹ Another third have limited mental health benefits, which limit the number of outpatient visits with a mental health professional and limit the number of covered hospital days—often at levels well below what is required to adequately treat mental illness. The rest have very little, no, or some unknown level of mental health coverage.

Mental health insurance also varies greatly depending on the source of the insurance. Nationally, employer-sponsored insurance provides similar benefits for physical as well as mental health problems for only 14 percent of individuals covered. Surprisingly, as firm size increases, the scope of mental health benefits provided decreases. About 23 percent of individuals with coverage through firms with 10 to 499 employees have mental health benefits similar to physical health benefits. In contrast, parity declines to six to eight percent of individuals who receive benefits from firms with 500 or more employees.²⁰

Coverage among public programs is equally as variable. Medicare (which covers adults 65 and older) requires patients to pay 20 percent of the cost (coinsurance) for services for physical health problems, but requires a 50 percent coinsurance for mental health outpatient services. Medicaid (which covers low-income women, children and disabled people) provides good coverage for mental health services for those few who qualify; however, in order to qualify, individuals must be sick *and* persistently disabled to access mental health services. On top of this, individuals cannot have more than \$2,000 in net assets. Clearly, neither program provides true parity for mental health services.

Figure 1. Individuals in U.S. Population with Parity in Mental Health Benefits, 1999



Source: MPR calculations based on data from the Current Population Survey, the Medical Expenditure Panel Survey-Insurance Component (MEPS-IC), the Mercer Worldwide Survey of Employer-Sponsored Health Plans, and program materials.

¹⁹ Maxfield, M., Achman, L. & Cook, A. (2004). *National estimates of mental health insurance benefits* (DHHS Pub. No. (SMA) 04-3872). Rockville MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

²⁰ Ibid.

For individuals with employment-based health insurance, mental health services are only covered as long as individuals can function well enough to continue working. The employer-based system can work well for individuals who have the good fortune to only need limited mental health services. They only need a minimal level of mental health services in order to recover and resume a normal life. However, individuals more seriously affected by mental health issues often quickly exceed their benefits and are then blocked from accessing further services. The situation often spirals down quickly as many are unable to maintain employment as their untreated mental illness worsens.

When private insurance does not cover needed mental health services, many people assume that the mental health safety net will be there to prevent them from falling through the cracks. Unfortunately, this is not the case.

Washington's Mental Health Safety Net

Washington's mental health safety net is experiencing significant changes in its funding and delivery structure. Historically, Medicaid has funded much of Washington's public mental health system. Medicaid patients received a set of mental health services in a managed care system. Since 1993, the state has been able to use the savings generated by Medicaid managed care to pay for mental health services for uninsured or "non-Medicaid" patients.

Beginning January 1, 2005, however, the federal government will no longer allow the use of savings from the Medicaid rates for any purpose except for Medicaid eligible persons and Medicaid covered services. It is estimated the state will lose at least \$23 million because of this change.²¹ In preparation for this, many of the Regional Support Networks (who administer the Medicaid mental health dollars) have begun turning away non-Medicaid individuals because there is no funding for their care. Thousands of these individuals are expected to begin seeking care and pharmaceuticals at local community health centers, hospital emergency rooms, and other organizations that provide charity care services. This increase will put additional pressure on an already stretched mental health safety net. Washington's community health centers have already seen a 112 percent increase in visits for mental health reasons from 2000 to 2003.²² The state has not yet designated a funding stream to pay for their care, and it is unclear how funding to pay for this care will be provided.

Barring the impact of this new restriction, two levels of coverage are currently available through the safety net: Crisis care and care for chronic mental health problems. Crisis services are available for people without private health insurance who are not eligible for mental health services from Medicaid. To access these services, they must have had a severe episode such as contemplated suicide. If they do qualify, care is limited to only two visits and individuals are then referred to their regular health care provider for follow-up services. Many end up in local community health centers and other primary care offices, which are rapidly becoming overburdened by these referrals. Private care from mental health care providers is also available, but only if the individual is able to pay out-of-pocket for these services. The majority of people cannot afford this option. Therefore, primary care providers now provide the majority of mental health care for these people.

²¹ Yowell, T. (2004). "Non-Medicaid" Mental Health Services and Financing. Prepared for the Joint Legislative & Executive Mental Health Task Force. Available from <http://www.leg.wa.gov/house/opr/MHTF/2004/July27.pdf>

²² US Department of Health and Human Services, Health Resources and Services Administration. (2003). *Uniform Data System, 2002-2003* [Data file]. Available from Health Resources and Services Administration Web site, <http://bphc.hrsa.gov/uds>

When people are in crisis, many in King County turn to the Crisis Triage Unit at Harborview Medical Center. This unit is structured to evaluate and triage people who are found to be severely disturbed and in crisis. On average, only 25 percent of the people presenting to this unit have any health insurance. The vast majority have no financial resources and are thus referred to a crisis provider for two outpatient visits, and then onto a primary care provider if available. Unfortunately, the majority of these people never follow up with any provider. These people are often not in the best frame of mind to make good decisions, which coupled with the discontinuity of service and difficulty accessing primary care providers at community health centers, leads very few to seek follow up care. For those people who are ill enough to be hospitalized, the duration of their stay is often shorter than necessary to adequately treat the episode, and only about half are eligible for any outpatient services once they have been discharged from the hospital (P. Byrne, personal communication, September 15, 2004).

To receive ongoing mental health services under the public system in Washington State, individuals must be severely and persistently ill for one year. Only about six percent of all people with mental illness qualify for these mental health services.²³ This leaves a large number of people unable to access the care they need—caught between the rare good private health insurance and a very small safety net.

Strain on Other Public Services

Lack of access to mental health services is causing undue pressure on other public services. One of the primary systems most severely impacted by this issue is the criminal justice system. Three times as many mentally ill individuals are in U.S. jails and prisons than are in our mental health wards.²⁴ In Washington State, between 16 to 25 percent of the incarcerated population has a mental illness (P. Lukevich, personal communication, November 9, 2004). In the county jail system, mental health treatment is not funded, so individual jails must purchase and dispense medications to inmates—if they choose to do so. Counseling services are not even offered. In most cases, inmates do not have adequate access to treatment. Thus, not only are these people clogging an already overcrowded system, they are not receiving the treatment they need to recover from their illness. Further worsening the situation, once they have served their time, the majority are released without the ability to access the mental health services they need to resume a normal life, perpetuating the circumstances that brought them to jail in the first place.

The Cost of Change

Health care costs are rising much faster than individuals, employers, and government can afford. However, these costs could be reduced by investing in preventive services that keep people out of the hospital and by improving the scope of mental health benefits in both private and public health insurance plans.

There is good evidence that increasing expenditures for mental health care reduces overall health care costs. For example, companies that have health plans with the highest financial

²³ Estimates for Washington based on data provided in Maxfield, M., Achman, L. & Cook, A. (2004). *National estimates of mental health insurance benefits* (DHHS Pub. No. (SMA) 04-3872). Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

²⁴ Fellner, J. & Abramsky, S. (2003). *Ill-Equipped: U.S. Prisons and Offenders With Mental Illness*. New York: Human Rights Watch.

barriers to mental health services have higher rates of psychiatric Long Term Disability (LTD) claims, and companies with easier access to mental health services see a reduced incidence of LTD claims.²⁵ In addition, a 1999 study of a large Connecticut corporation revealed that a 30 percent reduction in mental health services triggered a 37 percent increase in medical care use and sick leave by employees using mental health services, thus costing the corporation more money rather than less.²⁶

In the private sector, including full coverage for mental health services in employment-based insurance plans is estimated to increase the cost of premiums by less than one half of a percent in Washington State.²⁷ This minimal premium increase would be more than offset by decreases in other costs. Lost productivity from depression alone costs employers an estimated \$44 billion per year as a result of reduced performance and absenteeism.²⁸ Yet providing adequate mental health treatment to employees has been shown to reduce the percent of depressed people considered work-impaired from 31 percent to 15 percent in only nine weeks.²⁹ Full coverage not only would result in increased access to mental health services, but would also lower the overall costs to the system by reducing disability, other health care costs, workers' compensation costs, unemployment insurance costs, absenteeism, and poor job performance.

Solutions to the Crisis

A number of activities are currently underway in Washington State to address this crisis. Several legislative and associated committees and organizations are studying different aspects of the mental health system. In December 2004, the Joint Legislative and Mental Health Task Force plans to present a report on the current status of access to mental health services across the state. One of the immediate problems the state must resolve is the hole created in the mental health budget with the federal government's rule to limit the use of Medicaid funds to Medicaid participants only. While the recommendations of the task force may guide the development of good solutions to this pressing problem, immediate action is needed to address the dysfunction of our mental health system.

Actions that must be made now include:

1. Overcome the Stigma. Mental health needs to come out of the shadows and be understood as a set of diseases like diabetes, hypertension, and other medical problems that are treatable and can be improved with specific treatments and good care management. Educating the public and policymakers about the nature, prevalence and treatment of mental illness is key to reducing negative stereotypes about the mentally ill. This is a leadership issue the state must embrace in order to encourage real change.
2. Ensure Mental Health Parity. The most straightforward and cost-effective strategy that

²⁵ Salkever, D. S., Goldman, H., Purushothaman, M. & Shinogle, J. (2000). Disability management, employee health and fringe benefits, and long-term disability claims for mental disorders: An empirical exploration. *The Milbank Quarterly*, 78(1), 79-114.

²⁶ Rosenheck, R. A., Druss, B., Stolar, M., Leslie, D. & Sledge, W. (1999). Effect Of Declining Mental Health Service Use On Employees Of A Large Corporation: General health costs and sick days went up when mental health spending was cutback at one large self-insured company. *Health Affairs*: 18(5), 193-203.

²⁷ Bachman, R. E. (2004). *An Actuarial Analysis of Comprehensive Mental Health Parity for the State of Washington*. Prepared for the Washington Coalition for Insurance Parity. Atlanta, GA: PricewaterhouseCoopers.

²⁸ Stewart, W. F., Ricci, J. A., Chee, E., Hahn, S. R. & Morganstein, D. (2003). Cost of lost productive work time among US workers with depression. *Journal of the American Medical Association*, 289(23), 3135-3144.

²⁹ Jones, E. R. & Brown, G. S. (2003). Behavioral health care: A worthwhile investment? *Employee Benefit Plan Review*. 58(2), 13-14.

will improve the situation for a significant portion of Washington's adults and children is to require all insurers to cover mental health in the same fashion they do all other diseases. This requirement does not dictate the overall level of benefits, but eliminates the discrimination now experienced by most insured people with mental illnesses.

3. *Strengthen the Mental Health Safety Net.* The issues surrounding the safety net are large and fundamental. Over 80 percent of people who have mental illnesses have limited or no coverage and many turn to the safety net for mental health care. Washington's mental health safety net is very small compared to our peer states and does not adequately meet our needs. Recent changes have dramatically decreased the funding available for mental health services for uninsured, non-Medicaid people. More funding must be made available to safety net providers in order to ensure adequate access to inpatient and outpatient services, especially in the following areas:
 - a. Inpatient and outpatient services must be expanded to provide needed services to this population. Washington should raise the level of funding of our mental health safety net to a level comparable to our peer states.
 - b. Direct mental health services are limited and need more funding in order to care for the people currently in the system. Funding for hospital inpatient beds, residential facilities, crisis triage and treatment centers, community mental health centers, and the uninsured must be increased to meet our existing needs.
 - c. Primary health care providers must be given adequate support to provide mental health services, since they are the primary referral locations for many people without mental health insurance. Until adequate mental health services are available, the onus will continue to be on these providers to provide mental health services to the majority of those in need.