CAN CRISIS BEGET OPPORTUNITY?
WASHINGTON STATE'S RESPONSE TO THE MENTAL HEALTH FUNDING QUANDARY

EXECUTIVE SUMMARY:

I. INTRODUCTION: THE CRISIS FACING WASHINGTON STATE

Public sector services for children and adults with serious mental illnesses are at grave risk in Washington State, in part because the state of Washington has relied more heavily on Medicaid dollars to fund these services than almost any other state. State and Federal Medicaid accounts for 89% of the $750 million spent by the State on community mental health services. *The Evergreen State will lose approximately $82 million in federal Medicaid revenues over the next two years.*

The impending Medicaid reductions threaten to exacerbate already critical shortages in treatment and services for people living with mental illness. NAMI-Washington believes more state resources must be targeted for services to youth and adults with severe mental illnesses. Without them, the state will have to pay the much higher costs that accrue when people do not receive the services they need: more homelessness, more people with severe mental illnesses in jails and prisons, and ultimately, more cost-shifting to non-mental health systems that historically are left to "pick up the pieces" when mental health services fail. Moreover, people will suffer needlessly.

II. RESPONDING TO THE CHALLENGE -- LEGISLATION

In 2004, the Joint Legislative and Executive Task Force on Mental Health Services and Funding was convened to review the status of public mental health services in Washington State and to consider strategies for overcoming lost Federal revenues resulting from changes in Medicaid funding. For the 2005-2007 biennial budget, the Taskforce recommended that lost federal funds should be replaced with state funds, and called for changes in mental health care policy and priorities. In reaction to the recommendations of the Task Force, two bills have been introduced and are pending in the state legislature, HB 1290 and SB 5763**.**

NAMI-Washington supports HB 1290 but believes that more improvements in the delivery of mental health services and supports are needed to truly the address the needs of people with severe mental illnesses across the State.

NAMI-Washington enthusiastically supports most of SB 5763.

III. RESPONDING TO THE CHALLENGE -- EVIDENCE-BASED PRACTICES

"Evidence-based practices" (EBPs) are clinical and administrative practices that have been proven, through randomized clinical trials and "real-world" observations, to consistently produce specific, positive results.

Available data indicate that overall, Washington State has been moving to implement evidence based services in the community for people with severe and persistent mental illnesses. However,

the Mental Health Division must do a better job of collecting information on the services provided and must collect information on outcomes achieved through these services.

IV. RESPONDING TO THE CHALLENGE -- FINDING NEW WAYS TO PAY FOR SERVICES

In a time of tough choices, Washington should learn from other states that have developed innovative ways to generate revenues for services for vulnerable populations.

These include:

- Illinois -- a hospital tax levy will allow the state to capture $450 million in extra federal Medicaid money.
- Michigan --passed a 75 cent-a-pack increase in the state's cigarette tax to generate an additional $300 million annually for the state's Medicaid program.
- Vermont-- finances two-thirds of its Medicaid spending through a trust fund supported by tobacco revenues, provider taxes and general funds.
- Kentucky -- court fees collected in DUI cases are be used to provide mental health services in local jails.
- California-- 1 percent tax on all income in excess of $1 million is expected to generate $800 million for services to people with severe mental illnesses by 2006-2007.

V. RECOMMENDATIONS: TURNING CRISIS TO OPPORTUNITY

The following actions would enable Washington State to address the needs of its most vulnerable citizens with severe mental illnesses.

1. **Washington State must significantly increase its investment in the public mental health system to ensure that youth and adults with severe mental illnesses receive the treatment and services they so desperately need.** NAMI Washington applauds Governor Gregoire's recent budget which increases mental health funding by 8.6%. The Washington State Senate also deserves credit for increasing mental health funding in their budget proposal.

2. **Now is the time to increase efforts to facilitate the adoption of evidence based and emerging best practices for youth and adults with severe mental illnesses on a statewide basis.**

3. **There should be no further reductions in inpatient and residential bed capacity until there is adequate capacity in the community to address the needs of individuals receiving these services.**

4. **Pre and post-booking jail diversion services, including Mental Health Courts, should be established on a statewide basis.**

5. **Washington State's law pertaining to civil commitment of individuals with mental illnesses or chemical dependency should be amended to allow interested parties to petition for initial detention based on a good faith belief that a person presents a likelihood of serious harm or is gravely disabled.**

VI. CONCLUSION

The crisis precipitated in mental health funding is an opportunity for Washington State to make changes in its mental health system that will improve access to appropriate services for youth and adults with severe mental illnesses. Changes and improvements in the delivery of services will succeed only if adequate dollars are invested by the State into these services. Governor Gregoire's proposed increase in mental health funding represents a significant first step towards achieving the promise of better services for Washington's citizens with severe mental illnesses.

I. INTRODUCTION: THE CRISIS FACING WASHINGTON STATE

Public sector mental health services for children and adults with serious mental illnesses are at grave risk in Washington State in 2005. Like most states, Washington is faced with a serious budget deficit and is looking for ways to control state spending and/or generate more state revenues. And, this difficult challenge comes at a time when federal support for programs serving the most vulnerable of the Evergreen State's citizens is being curtailed.

Washington State has relied more heavily on Medicaid dollars to fund public sector services for children and adults with serious mental illnesses than virtually any other state. This reliance upon Medicaid to fund mental health services has left the state in a very tenuous position. State and Federal Medicaid accounts for 89% of the $750 million spent by the State on community mental health services. (Yowell, 2004). At the same time, the Federal government is becoming more aggressive in imposing and enforcing restrictions on the ability of states to draw down federal Medicaid dollars. Washington State will lose approximately $82 million in federal Medicaid revenues over the next two years because the Federal government will no longer allow it to use these dollars to serve non-Medicaid populations or provide non-Medicaid services to Medicaid eligible populations. (Cook, Tacoma News Tribune, 2005).

The impending reductions in federal Medicaid support for mental health services in the Evergreen State come at a time when the mental health system is already reeling from the effects of earlier cuts. Certain communities have been especially hard hit, including King County, which, without even factoring in the Federal Medicaid cuts, is slated to lose approximately $50 million in funding for mental health services over a five year period. Across the State, many people with the most severe mental illnesses do not have access to the treatment and community services they need. Unless the projected cuts in Federal Medicaid are replenished and even added to, the current crisis in the numbers of people with these brain disorders who are homeless or incarcerated will worsen.

In recent years, roughly 150 psychiatric beds at the State's two psychiatric hospitals have been eliminated. Savings accrued from the elimination of these beds have not necessarily gone into more community-based residential options or services for people with severe mental illnesses. Only $7 million of the roughly $15 million in savings from the elimination of hospital beds have been integrated into community mental health services, with the remaining $8 million placed into the general fund to address other, non-mental health budget concerns.

On the positive side, both Governor Christine Gregoire and key state legislators have demonstrated commitment to beefing up State funding for services for individuals with severe mental illnesses. The budget recently released by the Governor would increase mental health funding by 8.6% from the current expenditure authority, even when factoring in the Federal Medicaid cuts. And, the Senate's budget also contains significant increases in funding for services for people with severe mental illnesses, including full restoration of the Federal Medicaid cuts.

Increased mental health funding will not, in and of itself, lead to better outcomes for people with severe mental illnesses. This funding must be targeted for services with proven effectiveness in addressing the needs of these individuals. And, mental health providers and administrators must be held accountable for demonstrating the benefits of the services they provide. However, NAMI-Washington believes that additional state resources judiciously targeted for services to youth and adults with severe mental illnesses will prevent suffering and avoid the extremely high economic and personal costs that accrue when people with these illnesses do not receive appropriate services on a timely basis.

With appropriate evidence-based services, recovery, dignity and economic self-sufficiency are very possible for people with severe mental illnesses. Without them, the consequence will inevitably be more homelessness, more people with severe mental illnesses in jails and prisons, and ultimately, more cost-shifting to non-mental health systems that historically are left to "pick up the pieces" when mental health services fail.

II. RESPONDING TO THE CHALLENGE

In 2004, a Joint Legislative and Executive Task Force on Mental Health Services and Funding was convened to review the status of public mental health services in Washington State and to consider strategies for overcoming lost Federal revenues resulting from changes in Medicaid funding. NAMI-Washington provided extensive testimony and other information to the Taskforce and strongly supports many of the conclusions and recommendations contained in its report.

For the 2005-2007 Biennial budget, the Taskforce made two broad recommendations. First, lost federal funds should be replaced "with state-only funds, to the maximum extent possible, with conditions to be determined by the Legislature." Second, additional state funding, to the extent it is made available, "should be used to address (1) the lack of

community residential and psychiatric inpatient beds … (2) retaining existing community hospital and Children's Long Term Inpatient (CLIP) beds, and (3) meeting the need for forensic evaluations and beds" (Final Mental Health Task Force Recommendations, 2004).

The Task Force also recommended a number of policy changes, including:

- Maintaining State Hospital beds until additional residential capacity is added to the community;
- Suspending, rather than terminating eligibility for Medicaid when an otherwise eligible person is confined in a correctional facility or is a resident in a state hospital. For individuals not yet Medicaid eligible, expediting Medicaid applications upon discharge from hospitals or correctional facilities;.
- Providing greater State direction to Regional Service Networks (RSNs) regarding the use of State-only dollars for non-Medicaid services and priority populations; and
- Requiring the use of evidence-based practices in the treatment of mental illnesses and promotion of recovery from mental illness.

Two bills have been introduced and are pending in the State legislature, HB 1290 and SB 5763, to give effect to the recommendations of the Task Force.

HB 1290: The intent of HB 1290 is to create greater uniformity in the delivery of mental health services across the state, to increase the availability of recovery-oriented services and evidence based practices, to provide consumers and family members with a more significant role in the local design of services, and to address the critical need for the rapid restoration of Medicaid benefits for individuals discharged from psychiatric hospitals or correctional facilities.

NAMI-Washington supports HB 1290 but believes that more improvements in the delivery of mental health services and supports are needed to truly address the needs of people with severe mental illnesses across the State. Increasing the availability of evidence-based services such as Assertive Community Treatment (ACT) programs for adults with severe mental illnesses and wraparound services for children and adolescents with these illnesses are particularly important.

SB 5763: The intent of SB 5763 is multifaceted, including consolidating laws pertaining to involuntary commitment for mental illness and/or chemical dependency, expanding chemical dependency treatment programs for Medicaid eligible individuals with incomes under 200 percent of poverty, clarifying the authority to create mental health and drug courts across the state, and facilitating the timely determination of eligibility for SSI/SSDI and Medicaid/Medicare for individuals discharged from treatment or correctional facilities.

NAMI-Washington enthusiastically supports most of SB 5763. NAMI-Washington's comments on SB 5763 emphasize the need to maintain current "gravely disabled"

standards in the State's involuntary commitment statute, provide families and other caregivers with legal authority to initiate commitment proceedings, address workforce shortage issues by financing competitive pay rates for community mental health center line staff, and designate state matching funds to communities to establish and maintain police Crisis Intervention Team (CIT) programs using the Memphis best practice model.

III. THE CURRENT STATE OF PUBLIC MENTAL HEALTH SERVICES IN WASHINGTON STATE

The Mental Health Task Force's assessment of public sector mental health services in Washington State revealed significant shortages in inpatient capacity, intensive residential services, and evidence-based services for children and adults with severe mental illnesses in the community. It is noteworthy that these shortages existed even before the impacts of the $82 million cuts in Federal Medicaid were felt.

Inpatient Beds:
The Task Force reported that in 2003, approximately 75% of the inpatient beds were located at the State's two public psychiatric hospitals, Western State and Eastern State Hospitals. Twenty-five of thirty-nine counties had no community inpatient or Evaluation and Treatment Center (E&T) beds for individuals in crisis or under civil commitments. Moreover, the termination of the State's IMD waiver threatens the loss of further inpatient capacity in the future.

Community Services:
A 2002 study conducted for the State by the Public Consulting Group (PGC) revealed that the discharges of 22% of persons from state hospitals were delayed because of a lack of community programs and services for these individuals. Moreover, this same study showed that a quarter of all individuals admitted to state hospitals could have been avoided with appropriate community services.[1] (Public Consulting Group, 2004).

Services for Individuals under Involuntary Commitment Orders
The overall lack of inpatient and residential treatment capacity in Washington State has created barriers to inpatient treatment even for individuals who are under inpatient civil commitment orders. Since an inpatient civil commitment order is essentially a psychiatric emergency, depriving individuals under these orders of needed psychiatric treatment is cruel, inhumane and probably a violation of their constitutional right to treatment.

Services for Youth with Mental Illnesses:
The MHTF and PCG reports also documented significant strains on inpatient and residential services for youth with mental illnesses, as well as inadequate community-based alternatives for these youth. Funding issues in Washington State threaten the closure of inpatient beds for youth both in community hospitals and in programs administered by the Children's Long-Term Inpatient Placement Administration (CLIP).

[1] It should be noted that community services, as discussed in the PGC report, included intensive residential services in the community.

Moreover, most of the beds are concentrated in urban portions of the State – inpatient beds are not available at all for youth in more rural parts of the State.

On the community side, it appears that the availability of evidence based services for youth with mental illnesses are significantly lacking. As noted in the PGC's report, proven models of community-based care for children and adolescents with mental illnesses such as therapeutic foster care, wraparound care, intensive case management and multi-systemic therapy are very much needed. And, at a time of fiscal distress, these community-based services for youth could decrease the current pressures for inpatient and residential services.

IV. EVIDENCE-BASED PRACTICES IN WASHINGTON STATE: AN UNDERUTILIZED OPPORTUNITY

"Evidence-based practices" (EBPs) are clinical and administrative practices that have been proven, through randomized clinical trials and "real-world" observations, to consistently produce specific, intended results. For youth and adults with severe mental illnesses, these results entail recovery, as well as the prevention of the most damaging consequences of untreated mental illnesses, such as homelessness, criminalization, hospitalization, or suicide.

The Federal Substance Abuse and Mental Health Services Administration (SAMHSA) has identified six services for adults that constitute evidence-based practices.

- Assertive Community Treatment (ACT) programs;
- Integrated mental health and substance abuse treatment for people with co-occurring mental illness and substance use disorders;
- Supported employment;
- Medication management protocols;
- Family psycho-education programs; and
- Illness self-management programs.

Over the past year, NAMI collected data from the 50 states and the District of Columbia about the extent to which these EBPs are available for adults with severe mental illnesses. Additionally, NAMI has collected data on jail diversion programs and supportive housing programs.

Some states have been able to provide more comprehensive data than others. Unfortunately, Washington State has been able to provide only limited data. A possible limiting factor may be that public-sector mental health services are organized and administered through RSNs, thereby hampering the State from having the same access to data that it would conceivably have were these services administered at the State level. A snapshot of the data that was provided by Washington State follows immediately below.

In collecting data on the availability of evidence-based practices for adults with severe mental illnesses, NAMI used the very conservative estimate that 1 percent of

Washington's adult population, or 58,941 adults according to 2000 Census data, suffer from severe and persistent mental illnesses. In actual fact, the numbers of people with severe and persistent mental illnesses in the State are probably significantly higher. In 2003, 127,000 individuals were served by the public mental health system. Of these, 84,300 were on Medicaid and 42,600 were not.

Assertive Community Treatment (ACT) – ACT is one of the most well-documented services that help individuals with severe and persistent mental illnesses live in the community and avoid hospitalization. It consists of a diverse team of mental health providers who together, utilizing a triage type approach, provide comprehensive and integrated services for consumers, reaching out to them in their own communities and providing the full-range of services needed.

Three ACT programs serve individuals with severe and persistent mental illnesses in Washington. The Washington State Mental Health Division only reported in fiscal year 2002 that 7 people were served through ACT; a number that the Division admits is very low and not representative of the true number of individuals receiving ACT in the state. However, the state is also not able to report the level of financial investment in ACT programs. Obviously, many improvements are necessary to bring ACT to the people in Washington State who are most in need of this intensive program.

NAMI Expectations: 8,841 persons should be served by ACT programs in Washington State.

Integrated mental health and substance abuse treatment for people with co-occurring disorders – This optimal form of treatment for people with co-occurring disorders combines mental health and substance abuse treatment in one setting, with effective coordination and ongoing communications between treatment providers in both areas.

Improving services to people with co-occurring disorders is a goal of the Division, as described in its block plan for FYs 2005-2007. (Washington State Mental Health Division, 2005). For FY 2002, the Division reported 14 programs offering integrated mental health-substance abuse treatment in various parts of the state. However, no information was provided on the number of individuals benefiting from integrated treatment or the state's financial investment into these services.

Supported Employment – This employment service is the most effective in helping people with severe mental illnesses obtain and maintain competitive employment. Departing from the traditional "train-place" model of vocational rehabilitation, supported employment programs help consumers find jobs and provide job-coaching and ongoing supports on the job-site to maximize the chances of success.

Goal 11 of the FY 2003 Mental Health Block Grant report submitted by the Mental Health Division (the most recent report available) is to "increase supported education/employment opportunities for persons with mental illness". (Brimmer, 2003). A review of the report shows that the Division is engaged in a number of activities to try

to achieve this goal, including training consumers to be job coaches and supported employment providers and increasing supported employment opportunities in state government.

Unfortunately, despite the emphasis on supported employment in the State's Block Grant report, data reporting from the Division is insufficient to fully determine the extent to which this evidence based practice has been promulgated on a state-wide basis. The Division reported to NAMI that 1,661 individuals with severe and persistent mental illness are served by supported employment programs. However, the Division was unable to give an estimate of the number of programs that provide this service or the amount the state Division of Mental Health has invested in supported employment.[2]

Notably, the Washington State Division of Vocational Rehabilitation has implemented an "Order of Selection" because of limited funding. This has significantly reduced the availability of funding through that agency for supported employment services for people with severe mental illnesses.

NAMI Expectations: 29,470 persons served by supported employment programs.

Medication-Management – Various mechanisms can help translate the latest available knowledge about medications into practice by helping physicians and patients choose the appropriate medication. Decisions about medication must be made at the individual level, with the full-support of scientific evidence.

Washington State has not implemented medication management programs for either schizophrenia or bipolar disorder. This is a major failure with the potential to impact negatively on both consumer safety and the ability of the state to achieve greater efficiencies in its Medicaid program.

NAMI Expectations: All prescribers of medication for individuals with severe and persistent mental illnesses should utilize medication management programs.

Family psycho-education – Since family members of individuals with severe mental illnesses often provide support and care for their loved one, services that help them understand mental illness have been shown to help family members cope better and help consumers avoid psychiatric crises. An estimated 50 percent of family members provide intensive care for individuals with severe mental illness – and thus could benefit significantly from family psycho-educational services.

Fourteen programs reached out to 29,762 individuals to offer family psychoeducation and family therapy in FY 2002. It appears, based on this data, that the State is doing a good job of reaching out to families. However, no information is available about the nature or quality of these services. The Mental Health Division was also unable to provide information about expenditures on these services in FY 2002.

[2] It should be noted that the role of the Division is generally to fund extended employment supports. The Department of Vocational Rehabilitation is responsible for initial funding of these services.

NAMI Expectations: A mimimum of 29,470 family members should receive family psychoeducation services.

Illness self-management – Interventions that help consumers better understand their illness and take charge of their treatment decreases psychiatric symptoms and improves outcomes. All consumers with severe mental illnesses should have access to illness self-management.

For FY 2002, the Division was unable to provide meaningful data on the State's efforts to educate individuals with severe and persistent mental illness in managing their disorders. The State reported limited programs, but was not able to provide details or information on expenditures for this vital service.

NAMI Expectations: Illness self-management programs should be accessible to all persons in the state with severe and persistent mental illnesses.

Jail Diversion – An emerging best practice – Throughout the country, a variety of pre-booking and post-booking programs have emerged to facilitate alternatives to incarceration and to link people with severe mental illnesses with needed services. A growing body of evidence shows that these programs are frequently successful in reducing criminal justice involvement and enhancing public safety.

Washington State has made significant progress in certain parts of the State in recent years in implementing Mental Health Courts and other initiatives designed to create alternatives to incarceration for individuals with severe mental illnesses. Pre-booking diversion initiatives have been established in King, Pierce, Yakima and Grays Harbor counties.

A post-booking diversion program has been established in Pierce County, with community mental health service providers placed in the local jail to assist individuals with mental illnesses. In addition, five Mental Health Courts have been established across the State, including two in King County (Seattle).

Overall, Washington State has been moving to implement evidence based services in the community for people with severe and persistent mental illnesses. However, data collection limitations hampered our ability to derive a clear sense of just how widespread these services are in the State. The Mental Health Division must do a better job of collecting information on the services provided and must collect information on outcomes achieved through these services. At a time of fiscal constraints and budgetary restrictions, improved information of this kind is critical to protect and expand evidence-based practices.

V. THE MILLION DOLLAR CHALLENGE: FINDING NEW WAYS TO PAY FOR SERVICES

NAMI-Washington believes that the State must significantly increase access to evidence-based practices in the community, while not restricting the availability of inpatient or residential treatment options for those individuals who require them. The Joint Legislative-Executive Taskforce report similarly emphasized the need for these services. And, the two pending legislative initiatives, HB 1290 and SB 5673, contain provisions emphasizing the importance of increasing the availability of evidence based services on a statewide basis.

Nevertheless, with the loss of $82 million in federal Medicaid revenues, Washington State faces a significant challenge in raising the money to implement the Task Force recommendations and the requirements set forth in the two bills. These challenges are not unique to Washington – virtually all states are today grappling with significant budget shortfalls and limited options for generating new revenue. In Washington's case, this challenge is made even more formidable by the lack of a State income tax.
Both Governor Gregoire and leaders in the legislature are exploring options for generating increased state and local revenues for mental health services.

A February, 2004 report by McKinsey and Company, entitled "Achieving a Critical Mission in Difficult Times," provides a number of examples of strategies employed by States to generate revenues for health and social services for vulnerable populations. These include:

Illinois
Illinois was recently successful with the support of the Illinois Hospital Association in getting the Bush administration to sign off on a hospital tax levy that will allow the State to secure $450 million in extra Federal Medicaid money. The hospital tax will bring an additional $560 million to the State of Illinois. The State will then use these funds to boost Illinois' share of federal matching dollars for Medicaid.

Michigan
A 75 cent-a-pack increase has been added to the state's cigarette tax to generate an additional $300 million annually for the state's Medicaid program. These so-called "sin taxes," imposed on cigarettes, alcohol, and casinos, have been used in several States to generate revenues for healthcare and mental health treatment for vulnerable populations. Since 2001, 21 States have increased taxes on cigarettes to generate revenues for services.

For an example of a current legislative proposal in Tennessee to generate similar revenues, see http:www.legislature.state.tn.us.

Vermont
About two-thirds of Vermont's Medicaid spending is financed from their Health Access Trust Fund (HATF). Revenues for the trust fund come from tobacco (taxes as well as

part of the settlement from cigarette companies), provider taxes on hospitals, nursing homes and home health agencies, and an annual fund transfer from the General Fund.

Other States have employed creative strategies to generate revenues for mental health related services as well.

Kentucky
In 2004, Kentucky passed legislation, HB 157, authorizing Court fees collected in DUI cases to be used to create a triage system for screening jail inmates for mental illnesses and to provide mental health services in local jails throughout the State. More information about this legislation can be found at
http://www.lrc.state.ky.us/record/04rs/HB157.htm

California
The citizens of California attracted considerable attention in 2004 by passing Proposition 63, an initiative that imposes a 1 percent tax on all taxable personal income in excess of $1 million. This so-called "millionaires" tax is expected to generate $800 million in new revenues for services to people with severe mental illnesses by 2006-2007.

VI. RECOMMENDATIONS: TURNING CRISIS TO OPPORTUNITY

Cuts in vital mental health funding in recent years have taken their toll in Washington State. These cuts have exacerbated the suffering of people with the most severe mental illnesses – for these individuals, lack of appropriate treatment and services translates into hospitalizations, homelessness, criminalization, and sometimes death. Impending cuts to Federal Medicaid dollars threaten to worsen these problems.

These problems can be resolved only through multiple solutions, involving a combination of renewed State funding of services for youth and adults with severe mental illnesses and widespread implementation of services with proven effectiveness in addressing the needs of these individuals. The following recommendations, if implemented, would present an opportunity for Washington State to address the needs of its most vulnerable citizens with severe mental illnesses.

1. Washington State must significantly increase its investment in the public mental health system to ensure that youth and adults with severe mental illnesses receive the treatment and services they so desperately need.

The loss of $82 million in Federal Medicaid funding will cut off non Medicaid eligible individuals, many of whom suffer from severe mental illnesses, from needed mental health services. Additionally, many Medicaid eligible individuals will lose needed services such as crisis services, housing assistance, and care provided in Institutions for Mental Diseases (IMDs).

It has been well established that cuts in mental health funding lead to increases for other systems left to "pick up the pieces" – criminal justice, homeless services, and indigent

care hospitals, to name a few. NAMI-Washington calls upon the State to invest adequate funding into the public mental health system to not only replace the lost Federal Medicaid revenues but also the funding that has been lost in recent years through reductions in inpatient beds in the state hospital system.

NAMI-Washington notes with gratitude the recent budgets submitted by Governor Christine Gregoire and the Washington State Senate, both which would increase mental health funding significantly, even when factoring in the Federal Medicaid cut. We applaud the Governor and leaders in the Senate for their commitment to protecting and enhancing public mental health services.

2. With new leadership demonstrating a renewed commitment to mental health, this is the time to increase efforts to facilitate the adoption of evidence based and emerging best practices for youth and adults with severe mental illnesses on a statewide basis.

NAMI's survey of evidence-based practices in Washington State revealed that these services are available only on a piecemeal basis throughout the State. In some regions, it appears that services for adults such as ACT, supported employment, and integrated mental health and substance abuse treatment, and services for youth, such as wrap-around services and multi-systemic therapy are not available at all. Without these services, recovery is simply not possible for people with severe mental illnesses. Moreover, in some parts of the State, access to evidence based mental health services is limited to those individuals who are in acute psychiatric crisis. This is a "penny-wise, pound foolish" approach.

NAMI-Washington realizes that authority over services and spending for these services is decentralized in Washington State. However, the State must engage in enhanced efforts to promote the implementation of services that work, monitor how these services are being provided, and collect data on the extent to which these services are provided and the outcomes achieved. Finally, eligibility for services should not be limited to those who are in crisis – early interventions before crises occur can both prevent unnecessary suffering and save money in the long run.

3. No further reductions in inpatient and residential bed capacity should occur until there is adequate capacity in the community to address the needs of individuals receiving these services.

Simply stated, there are inadequate comparable community-based services available for youth and adults with severe mental illnesses discharged from inpatient treatment facilities or deprived of admissions to these facilities due to the lack of adequate beds. A recent evaluation of Western State Hospital discharge records found that approximately half of these discharges "did not meet professional standards". A further review revealed that many vulnerable patients are being discharged to circumstances that place them "at risk of suffering immediate and irreparable harm". (Washington Protection and

Advocacy System, 2005). It has also been documented that in many parts of the State, there are no treatment beds available for individuals civilly committed to inpatient treatment facilities.

The elimination of inpatient beds is a tempting strategy when budget pressures are brought to bear. However, the U.S. Supreme Court's decision in Olmstead v. LC, 527 U.S. 581 (1999), was not a mandate to close hospitals. Rather, the decision dictated that states have an obligation, under the Americans with Disabilities Act (ADA), to assist individuals to find appropriate services in the most integrated setting appropriate to their needs. The discharge of individuals from hospitals without adequate services and supports to address their needs is a clear violation of this decision.

4. Establish CIT programs, Mental Health Courts, and other jail diversion services on a statewide basis. These services should include mental health and criminal justice triage mechanisms to ensure timely mental health interventions and prevent unnecessary incarcerations.

There has been good progress, in certain parts of the State, to facilitate alternatives to incarceration for low-level, non-violent offenders with severe mental illnesses who require treatment, not incarceration. However, there are still far too many people with schizophrenia, bipolar disorder and other severe mental illnesses who are being incarcerated simply for the "crime" of having a mental illness.

Jail diversion programs have proven effectiveness both in enhancing public safety and in reducing high-end costs associated with hospitalizations and incarcerations. (Council of State Governments, Criminal Justice/Mental Health Consensus Project, 2005). Building on effective models that already exist in King County, Spokane County, Pierce County, and elsewhere, Washington-State should move to adopt these cost-effective programs on a statewide basis.

The State should also follow the lead of communities such as Seattle, Spokane and Vancouver by developing triage mechanisms for responding to the needs of non-violent individuals who come into contact with criminal justice systems. Criminal justice-mental health partnerships in developing triage capabilities such as psychiatric emergency rooms both improve treatment outcomes and enhance the safety of law enforcement officers and the public.

5. Washington State's law pertaining to civil commitment of individuals with mental illnesses or chemical dependency should be amended to allow interested parties to petition for initial detention based on a good faith belief that a person presents a likelihood of serious harm or is gravely disabled. An "interested party" means a guardian, spouse, parent, adult child, close adult relative, a responsible adult friend or a person who has the individual with mental illness or chemical dependency in his/her charge of care.

Currently, Washington State's law only allows these petitions to be initiated by county-designated crisis responders. Families or other caregivers are frequently best able to determine when individuals are at risk but are not allowed under current law to initiate these petitions. This creates significant barriers to vulnerable individuals receiving timely treatment interventions when they most need them. Forty –five states and the District of Columbia recognize the critical role that families can play in facilitating timely and appropriate treatment interventions for individuals most at risk. Washington State should similarly amend its statute to provide families or other caregivers with similar legal standing.

VII. CONCLUSION

The crisis precipitated by recent cuts in mental health funding and exacerbated by the impending loss of Federal Medicaid revenues is an opportunity for Washington State to look closely at its mental health system and make changes that will improve access to appropriate services for youth and adults with severe mental illnesses. Changes and improvements in the delivery of services will succeed only if adequate dollars are invested by the State into these services. The proposed increase in mental health funding in the budgets submitted by Governor Gregoire and the Senate represent a significant first step towards achieving the promise of better services for Washington's citizens with severe mental illnesses.

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