Wisconsin Women's Mental Health
Preliminary Report

Prepared for the
Wisconsin Women Equal Prosperity Symposium
June 29, 2004

In 2002, Wisconsin Lieutenant Governor Barbara Lawton launched the *Wisconsin Women = Prosperity Initiative* to improve the well-being of women in the state. The Initiative has its roots in the *Status of Women in the States*, a biennial state-by-state comparison compiled by the Institute for Women's Policy Research (IWPR). Among other troublesome findings for the state, the IWPR gave Wisconsin a poor evaluation on women's mental health. To inform and motive policy discussions on mental health, this preliminary report aims to define the relevant research questions, highlight existing data, and propose future steps to improve Wisconsin women's mental health.

Research Questions

Initial research on the mental health of Wisconsin women has produced four major questions:

► **Is the mental health of Wisconsin women a problem requiring state action?**
We will explore the extent to which poor mental health is a problem for Wisconsin women in absolute terms, as well as in comparison to women in other states and to men in Wisconsin. This will involve gathering and comparing data from national and state resources to the IWPR indicators.

► **What are the economic consequences of poor mental health?**
We will highlight the growing body of literature that quantifies the costs of poor mental health. We will discuss how the individual issue of women's mental health translates into a public problem.

► **What are the major barriers to better mental health for Wisconsin women?**
Our research will also focus on obstacles to mental health care access from the users' and providers' perspectives. Where possible, we will identify common patterns that enable or hinder mental health care.

► **What state policies could be implemented to improve the mental health of Wisconsin women?**
Drawing on our research and on feedback from various stakeholders, we will propose action items to understand and address better the mental health needs of the state's women.

Indicators of Wisconsin Women's Mental Health

As part of their overall health index, the Institute for Women's Policy Research used two measures to assess states on women's mental health:

► **On poor mental health days, Wisconsin ranked a low 48 of 51 states**. Wisconsin women self-reported an average of 4.4 poor mental health days per month compared with 3.8 nationally.[i] [ii] This translates into 46 percent of Wisconsin women reporting at least one day of poor mental health in the last month, significantly higher than the national median of 40 percent.

► **On mortality from suicide, Wisconsin ranked more favorably at 16 of 51 states.** For Wisconsin women, the average annual mortality rate from suicide is 4.0 per 100,000 persons, below the national average of 4.4.[iii] The suicide rate is a proxy for mental health status because it occurs most frequently as a consequence of a mental disorder.[iv]

Interpreting the Rankings

Caution should be exercised when interpreting the meaning of the IWPR rankings, particularly on the topic of mental health.

► **Too few measures of mental health.** The IWPR bases its state rankings on only two indicators of mental health. There is a question of whether or not these measures are sufficiently robust to form an index for women's mental health.

► **Potential seasonal effects on survey responses.** The survey on the number of poor mental health days is sensitive to the season in which it is administered, with winter months showing a systematic tendency for more poor mental health days. Further investigation into the timing of Wisconsin's survey may reveal that the season affected Wisconsin women's responses.

► **Definition of mental health may be too broad.** The measure of poor mental health days utilizes a broadly defined conception of mental wellness. The measure does not separate mild depression from severe depression or from other forms of chronic mental illness. For the purpose of designing state policies, it may be advantageous to distinguish general mental wellness from severe mental illness.

Mental health data collected by Wisconsin agencies is also limited. As a 2003 review of women's health points out, the State of Wisconsin lacks uniformly collected data on mental health.[v] Without more comprehensive measures and consistent data collection, it is difficult to fully account for the scope and nature of mental illness among women in Wisconsin.

Additional Data

While these shortcomings are notable, existing data is strong enough to indicate that women's mental health is worth attention in the state. The following is a snap-shot of the mental health status of women and the public services available in Wisconsin. Table 1 corresponds with the narrative.

Depression

► This mood disorder is the **number one cause of disease-related disability for women** in the world. Moreover, **females are twice as likely than males to experience**

depression. [vi] Research suggests hormonal factors increase women's susceptibility to depression. Psychosocial factors also may contribute to the higher rates of depression among women. These include: multiple roles at home and work, and a greater likelihood of being poor, being at risk for violence and abuse, and being a single parent.[vii]

► **The gender difference is evident in Wisconsin.** Thirteen percent of women, compared to six percent of men, reported that they had been diagnosed with depression at least once in their lifetime.[viii] In raw numbers, this equates to 259,000 women and 124,000 men who have been diagnosed.

Table 1: Mental Health Status and Care in Wisconsin

	All	Men	Women
Percent of Wisconsin Adults:			
Reporting Poor Mental Health in Last Month [a]	40%	33%	46%
Ever Diagnosed with Depression [b]	10%	6%	13%
Ever Diagnosed with Anxiety Disorder or Post-Traumatic Stress Disorder [b]	6%	4%	8%
Who Received Mental Health Care in Past Year [b]	8%	7%	8%
Average Annual Mortality Rate from Suicide [c]		19.3	4.0

Sources:

a: 2001 Behavioral Risk Factor Surveillance System Online Prevalence Data, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention.
b: Standard errors are +/- 1 percent. 2002 Family Health Survey, Bureau of Health Information, Division of Health Care Financing, Wisconsin Department of Health and Family Services.
c: Rate is per 100,000 people. 1996-1998 National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

► **Anxiety disorder and post-traumatic stress disorder** are less common than depression at 8% (159,000) of women and 4% (71,000) of men reporting being diagnosed. The gender gap exists with this condition as well.

Suicide

► **The differences between men's and women's experience with suicide is striking.** Nationally, men's mortality from suicide is four times higher than women's. In Wisconsin, men are almost five times more likely than women to die by suicide. What is not reflected in this statistic is that women attempt suicide approximately two to three times more than men.[ix]

Use of Mental Health Care

► National surveys indicate that **approximately 40 percent of women do not seek treatment** for their mental health issues.[x]

► Interestingly, although women suffer from depression and anxiety disorders more often than men, **Wisconsin women receive mental health care only slightly more often than men**.[xi] In 2002, the number of women and men receiving care was 224,000 and 175,000, respectively.

The next question is what mental health resources are available to women in Wisconsin. Though the data presented here is limited to state expenditures, state services for the most vulnerable (i.e. those with the need for inpatient services and those unable to afford care) may be an indicator of the state's general commitment to mental health care.[xii]

Public Psychiatric Care

► According to the most recent data from 1998, **Wisconsin has 652 inpatient beds** in public facilities; this is **almost half the number available in Minnesota.**

► When comparing the number of psychiatric patients to the number of beds, Wisconsin's ratio of 1 bed to 2 patients is well below the national average. [Does this make sense?]

State Mental Health Agency Expenditures

► Wisconsin's financial commitment to mental health care puts the state in the middle of the pack. The Wisconsin mental health agency spent 389.4 million in 2001. Taking population into account, **Wisconsin spent $72 per capita on mental health services, ranking the state 27 of 51.** This figure compares to a national average of $84 per capita and Minnesota's $105 per capita.

Economic Rationale for Improving Wisconsin Women's Mental Health

The statistics above highlight the extent to which Wisconsin women personally struggle with mental health issues. With question, depression and other illnesses detract from the quality of these individuals' lives. While this may be sufficient cause for state involvement in the mental health system, the most persuasive link between women's mental health and public action is the adverse economic impacts of mental illness. Below is a sample of research demonstrating the financial costs of depression and other mental health conditions.

Cost to individuals

► **Poor mental health stands in the way of educational and professional achievement.** Researchers have found that early on-set depression, for instance, reduces the probability that a female will complete a college or master's degree. [xiii]

► As a result of lower human capital, women with early-onset depression face **future earnings that are 12-18% lower** than women with onset after age 21 or never. [xiv]

► **Women surveyed in 2003 ranked depression as the number one barrier to workplace success**, ahead of child care responsibilities, sexual harassment and sexism.[xv]

Cost to employers

► **Lost productivity from poor mental health represents a large costs for employers**. According to a 2004 study, mental illness was the 3rd most expensive of the top ten health conditions. [xvi] (See Table 2).

► In a national survey of working women conducted in 2003, **56 percent** of women with ongoing symptoms of depression say that their symptoms have **hampered their workplace performance at least occasionally** in the last four weeks.[xvii]

► An estimated 18 percent to 62 percent of total mental health costs are from presenteeism (i.e. on-the-job productivity losses). Presenteesim, along with absences, often are not included with the straightforward costs of insurance and employee assistance plans. Therefore, many **employers do not account for a large portion of the costs their employees' poor mental health.**

► Moreover, evidence shows that **women's mental health problems are more costly to employers than men's.** Analysis of data from Fortune 100 companies shows that the average female employee with depression amounted to $9,265 compared to $8,502 for male employees with depression. Women's greater absenteeism explains the gender difference.[xviii]

Table 2: Costs to Employers Associated with Depression/Sadness/Mental Illness [1]

	Cost	Rank [2]
Absenteeism [3]		
Average Days per Year Absent	25.6	1st
Average Dollar Impact per Year	$4,721	
Presenteeism		
Average Hours Lost per Day	1.2	3rd
Average Dollar Impact per Day	$28	
Total Cost, per employee per year [4]	$348	3rd

Notes:
1: The synthesis of six databases required collapsing their different measures of well-being into a composite category of depression/sadness/mental illness.
2: The rank for depression/sadness/mental illness is relative to the costs of nine other health conditions: allergies, arthritis, asthma, autoimmune diseases, any cancer, diabetes, heart disease, hypertension, migraine/headache, and respiratory disorders.
3: Dollar impact assumes 240 eligible working days.
4: The total cost is an aggregate, including medical, absence, STD, and average presenteeism costs.
Source: Ron Z. Goetzel, et al., "Health, Absence, Disability, and Presenteeism Cost Estimates of Certain Physical and Mental Health Conditions Affecting U.S. Employers." *Journal of Occupational and Environmental Medicine* 46 (2004).

Cost to public systems and society [xix]

► **Uncompensated care is costly to mental health providers.** In 2002, twelve psychiatric and other specialty facilities in Wisconsin reported $20.9 million in uncompensated costs.

► **Psychiatric hospitals report that 20.6% of their costs are uncompensated**, higher than general medical-surgical, alcohol and other drug addiction, and rehabilitation facilities. This unfavorable ranking holds whether uncompensated care is measured against total gross patient revenue or total gross non-government patient revenue.

Barriers to Better Mental Health Care

Given the individual and public burdens of mental illness, the next step is to understand the obstacles to more effective and efficient care. Initial interviews with several mental health professionals and with state policymakers have begun to frame the difficulties in accessing, delivering and regulating the mental health care system.

Professionals' Perspectives

► **Practices among general practitioners, psychologists and psychiatrists vary.** An increasing number of non-psychiatric doctors are prescribing anti-depressants, often without referring patients to psychiatric care or counseling. Research has demonstrated that a combination of prescription medication and counseling is the most effective treatment for depression. When medication is the only treatment, the link between patient and professional is tenuous, making the mental health care less consistent and monitoring of patient outcomes weaker.

► **Providers struggle to obtain adequate reimbursement.** As cited above, mental health providers often do not receive full payment for the services they provide, particularly

when the third-party payer is a government medical assistance program. To avoid these losses, providers ultimately offer a sub-optimal level of mental health services.

► **Paying third parties circumscribe the amount of care through capitation and treatment requirements.** Insurance companies limit their liability for mental health services through capitation, which is a limit on the total amount they will cover in each year and in a lifetime. An individual with a chronic mental disorder is likely to reach her/his maximum coverage, forcing her/him to turn to a public program, to their own savings, or to forego treatment. Treatment protocol set by third-parties, such as the frequent submission of new treatment plans, increases the administrative burden on providers and reduces the time they can serve people directly.

► **Outpatient care is difficult to maintain in the current system.** Mental heath care providers have a limited ability to follow the treatment of a patient when s/he is not in inpatient care. Currently, psychiatric doctors are often unable to properly monitor their patients once they leave inpatient care.

Third Parties' Perspective

► **Employers, particularly small businesses, are not inclined to offer more comprehensive mental health coverage.** In a discussion on mental health legislation, Senator Mary Panzer pointed out the concern of small businesses over increased insurance costs. From the perspective of many employers, the added expense of better mental health insurance for their employees exceeds the benefits to productivity of having a healthy workforce.

► **The State Legislature continues to deliberate mental health parity legislation.** Currently, only a handful of states require mental heath and physical disorders to be covered equally, but many more require near- or limited-parity for depression and eating disorders.[xx] For the past several sessions, the Senate and Assembly has been unable to reach agreement on legislation to require insurance companies to cover more mental health services. Progress was made recently; the 2003 Joint Legislative Council's Special Committee on Mental Health Parity developed Act 178, which was enacted into law April 2004. It created a series of provisions related to the treatment of prescription drug costs, diagnostic testing, and payments made under mandated insurance coverage of treatment for nervous and mental disorders and alcoholism and other drug abuse problems.[xxi]

Next Steps

This report only begins to describe the nature of Wisconsin women's mental health issues. Continued research and more interviews with professionals and patients hopefully will allow us to present a more comprehensive report on Wisconsin's mental health system. Areas of further investigation include:

► **Finding ways to expand data-collection efforts.** We will see what additional measures would be useful and how these the new data could be collected in a cost effective manner.

► **Analyzing how women's mental health is impacting Wisconsin economically.** While a comprehensive economic model is beyond the scope of this research project, we will seek out economic data that is specific to Wisconsin.

► **Looking at how Wisconsin has attempted to meet the goals of the 1997 Blue Ribbon Commission on Mental Health and the national *Healthy People 2010* report.** The goals to increase the number of persons who receive mental health screening and assessment in primary care, and to track consumers' satisfaction with their mental health services, are particularly noteworthy.

► **Gathering feedback from stakeholders in the mental health system.** We want to know in more detail what patients, professionals and policymakers identify as critical issues in the system. Their perspectives will provide guidance for the direction of the final report.

Notes

[i] The IWPR report included the 50 states and the District of Columbia in the rankings.
[ii] Original data source: National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, *Behavioral Risk Factor Surveillance System Online Prevalence Data*, 2001.
[iii] Original data source: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 1996-1998.
[iv] National Institutes of Health, and Substance Abuse and Mental Health Services Administration, "Mental Health and Mental Disorders," *Healthy People 2010-Conference Edition*, Chapter 18, November 1999: 18-3.
[v] Jennifer Whitfield, Lisette Jehn, Katherine Kvale, Joy Grotsky, Patrick Remington, and Millie Jones, "Forward for Women's Health: The State of Women's Health in Wisconsin," *Wisconsin Medical Journal* 102 (2003): 22-28.
[vi] *Journal of Effective Disorders* 74 (2003): 5-13.
[vii] National Institute of Mental Health, "Women Hold Up Half the Sky; Women and Mental Health Research," NIH Publication No. 01-4607, 2001.
[viii] Wisconsin Department of Health and Family Services, Division of Health Care Financing, Bureau of Health Information. Wisconsin Family Health Survey, 2002 (PHC 5379) April 2004.
[ix] National Institute of Mental Health, "Women Hold Up Half the Sky; Women and Mental Health Research," NIH Publication No. 01-4607, 2001.
[x] National Mental Health Association, and American Women's Health Association, "Depression Among Women in the Workplace," 2003.
[xi] Wisconsin Department of Health and Family Services, Division of Health Care Financing, Bureau of Health Information. Wisconsin Family Health Survey, 2002 (PHC 5379) April 2004.
[xii] Admittedly, data on inpatient facilities is not likely to represent the mental health services available through the entire health care system in Wisconsin. Likewise, using state expenditure data leaves out a large proportion of transactions because private insurance companies and patients often pay for mental health services.
[xiii] *American Journal of Psychiatry* 157 (2000): 940-947.
[xiv] *American Journal of Psychiatry* 157 (2000): 940-947.
[xv] National Mental Health Association, and American Women's Health Association, "Depression Among Women in the Workplace," 2003: 3.
[xvi] Ron Z. Goetzel, et al., "Health, Absence, Disability, and Presenteeism Cost Estimates of Certain Physical and Mental Health Conditions Affecting U.S. Employers." *Journal of Occupational and Environmental Medicine* 46 (2004).
[xvii] National Mental Health Association, and American Women's Health Association, "Depression Among Women in the Workplace," 2003: 3.
[xviii] *Journal of Affective Disorders* 74 (2003): 15-22.
[xix] Wisconsin Department of Health and Family Services, "Uncompensated Health Care Report-Wisconsin Hospitals, FY 2002."
[xx] National Women's Law Center, and Oregon Health and Science University, "Making the Grade on Women's Health: A National and State-by-State Report Card," 2001.
[xxi] Wisconsin Legislative Council Act Memo, 2003 Wisconsin Act 178 [2003 Senate Bill 71].