

**TESTIMONY OF THE  
NATIONAL ASSOCIATION OF  
STATE MENTAL HEALTH PROGRAM DIRECTORS  
TO THE  
PRESIDENT'S NEW FREEDOM COMMISSION ON MENTAL HEALTH**

**July 18, 2002**

Chairman Hogan and members of the Commission, thank you for the opportunity to testify today. My name is Robert Glover, and I am Executive Director of the National Association of State Mental Health Program Directors. NASMHPD represents the nation's \$22 billion state-administered public mental health system serving 6.1 million people in 50 states, four territories, and the District of Columbia.

On behalf of NASMHPD and the nation's state and territorial mental health agencies, please accept my congratulations on the establishment of this historic Commission and your appointments to it. We are encouraged that this Administration has highlighted mental health as a top policy priority and strongly support your efforts.

I will confine my remarks to highlighting the challenges facing state public mental health systems today. I will not suggest solutions at this time, for we hope to arrive at these as we work with you during the next year to examine the system, to develop recommendations for policy changes, and, as the President emphasized in his announcement and in his Executive Order, to propose a strategy for implementation.

Although state mental health agencies vary dramatically in terms of organizational structure, resources, and methods, they share a common mission: to promote and enhance mental health and recovery for all citizens with mental illness by providing quality mental health services in a manner that guarantees consumers compassion, dignity, and respect. For those of us who are responsible for carrying out this mission, these are promising times because remarkable advances are being made in the treatment of mental illness. As the Commission has heard repeatedly since its formation, states are struggling to ensure that consumers have access to these innovative and effective treatments and services. For this reason, many mental health advocates have described our public mental health system as one in crisis. While a few states and communities are able to meet the demand for services with effective, comprehensive treatment and community supports, others lack the necessary resources needed to serve even those with the most severe needs. Indeed, many state mental health agencies readily acknowledge that their systems are inadequate to fulfill their missions.

State public mental health systems bear little resemblance to the systems of a generation ago. Since 1960, the number of patients in state hospitals has declined from approximately 560,000 to under 50,000 in 2001. And state mental health agencies' expenditures have adjusted accordingly with approximately 64% going to community-based services and the balance to

inpatient care. [see attached chart A]. At the same time, several factors confronting state mental health agencies have combined to create a situation in which demand for services is growing while critical resources are dwindling [see attached chart B]. State budget shortfalls, long-term erosion of state general revenue funds for mental health, and a growing reliance by states on Medicaid and other federal programs to fund mental health services all are contributing factors to this inability to serve those in need with appropriate and effective care.

Although states are responsible for administering and managing mental health systems, the federal government plays an enormous role in funding services through numerous programs. Almost invariably, however, these programs fail to address the particular needs of individuals with mental illness, which leads to the development of a fragmented system of care. The Community Mental Health Services Performance Partnership Block Grant – the only significant federal program specifically designed to support community-based public mental health services – is currently funded at \$433 million, approximately 1.6 percent of state mental health agency expenditures.

Medicaid deserves particular attention. While Medicaid has become an invaluable and significant funding source for public mental health services, the program's eligibility and coverage rules limit its usefulness in the public mental health system. Because it is not designed specifically for mental health consumers, it generally supports a medical model of treatment, and, therefore, does not recognize the important social supports – such as housing and employment services – that are essential to successful recovery in the community. Yet it drains the states of general fund appropriations to meet the state Medicaid match, leaving state mental health agencies with fewer dollars with which to provide services.

Medicaid has been used more effectively to serve many other disability groups through home- and community-based waivers, which permit states to tailor service packages to meet the unique needs of specific, priority populations. However, states are effectively barred from obtaining these waivers to support people with mental illnesses in community settings, because Medicaid's discriminatory exclusion of services provided in institutions for mental disease – known as the IMD exclusion – makes it impossible for states to demonstrate the cost-neutrality that is a precondition to obtaining a waiver.

Other important federal programs are equally non-responsive to the unique needs of individuals with serious and persistent mental illnesses. The starting point of successful community living is access to a decent, safe, and affordable home, but federal housing policy has done little to address this need. Because of their low incomes, individuals with mental illness, particularly those who receive Supplemental Security Income (SSI), are, without significant housing assistance, effectively priced out of every housing market. Yet since the mid-1980s we have seen dramatic cuts in federal support for deeply subsidized housing, inadequate levels of Section 8 housing subsidies, the exclusion of persons with disabilities from “elderly only” housing, and the conversion of existing low-income housing to market rate housing. The Commission must address housing policy if the other advances it contemplates are to be achieved.

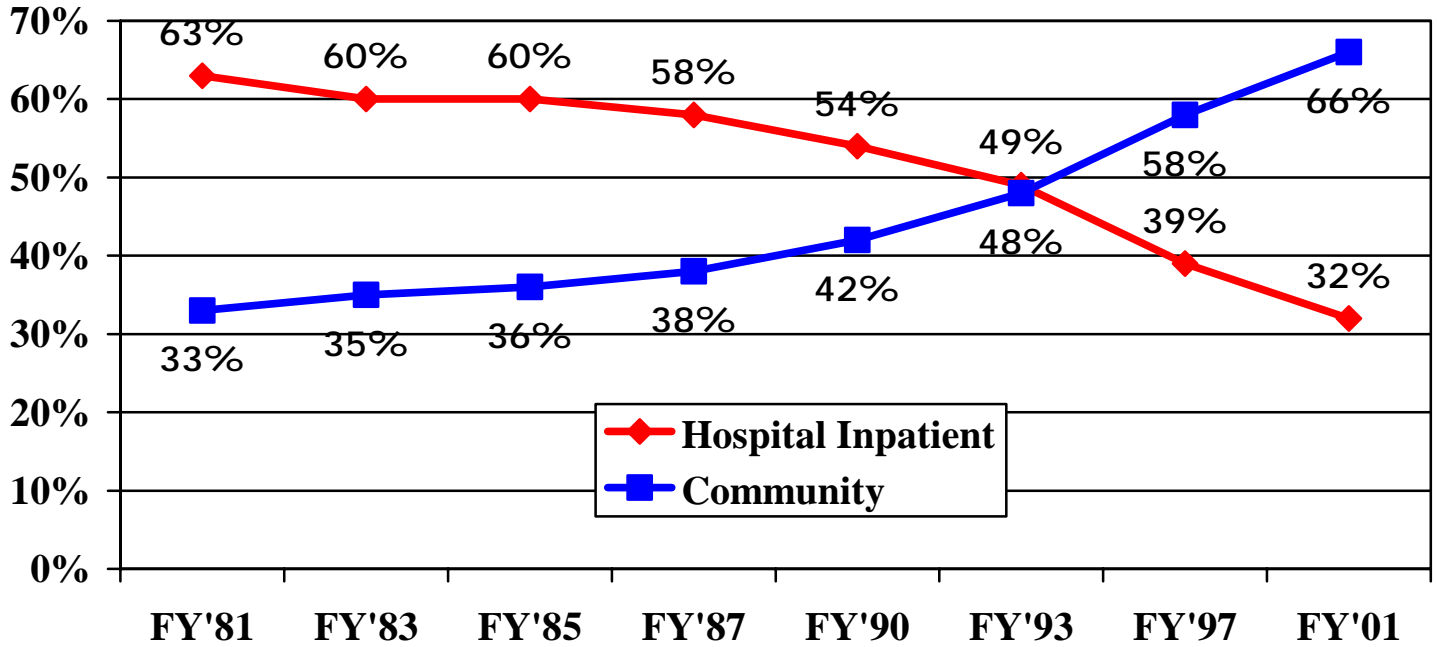
The Commission must also consider employment policies. Federal vocational rehabilitation programs historically have focused on providing specific medical devices and job training to individuals with disabilities and placing them in full-time, permanent positions, and closing their cases. Unfortunately, this approach is generally not effective in addressing the cyclic, persistent nature of serious mental illnesses. Research has documented the effectiveness of “supported employment” models, which emphasize rapid placement in a real job setting and ongoing support in varying intensity from a “job coach” to learn, adapt, and maintain the position. As is so often the case, we know which services are effective in promoting community-based recovery, but effecting the necessary policy changes within a program that is unable or unwilling to accommodate the needs of individuals with mental illness has proved daunting.

Too often, our inability to weave together this complicated array of funding mechanisms leaves many individuals with severe mental illness without services that we know would work, and in many cases, such individuals come in contact with the criminal justice system. Indeed, according to the Department of Justice, people with mental illness represent approximately 16 percent of the prison and jail population. This summer, the Council of State Governments (CSG) and an unprecedented coalition of organizations from the law enforcement, judicial, corrections, and mental health fields released a comprehensive report – the *Criminal Justice/Mental Health Consensus Project* -- that stresses the need for early intervention and collaboration between the mental health and criminal justice systems. Implementation of its many recommendations would greatly improve the lives of many with mental illness, while relieving the criminal justice system of responsibilities for which it is neither designed nor equipped. We urge you to review the findings and recommendations of the *Consensus Project* and to ensure that the Commission’s report to the President address this matter.

We also encourage the Commission to give special attention to the disturbing findings documented in the Surgeon General’s 2001 Supplement to its Mental Health Report, *Mental Health: Culture, Race, and Ethnicity*. Most notably, that racial and ethnic minorities have less access to mental health services; that those in treatment receive poorer quality mental health care; and that they suffer disproportionate levels of disability due to their unmet mental health needs. NASMHPD has identified such disparities in the mental health field and the provision of culturally and linguistically appropriate and accessible mental health services as a priority, and we hope to work with the Commission in addressing this matter in its report to the President.

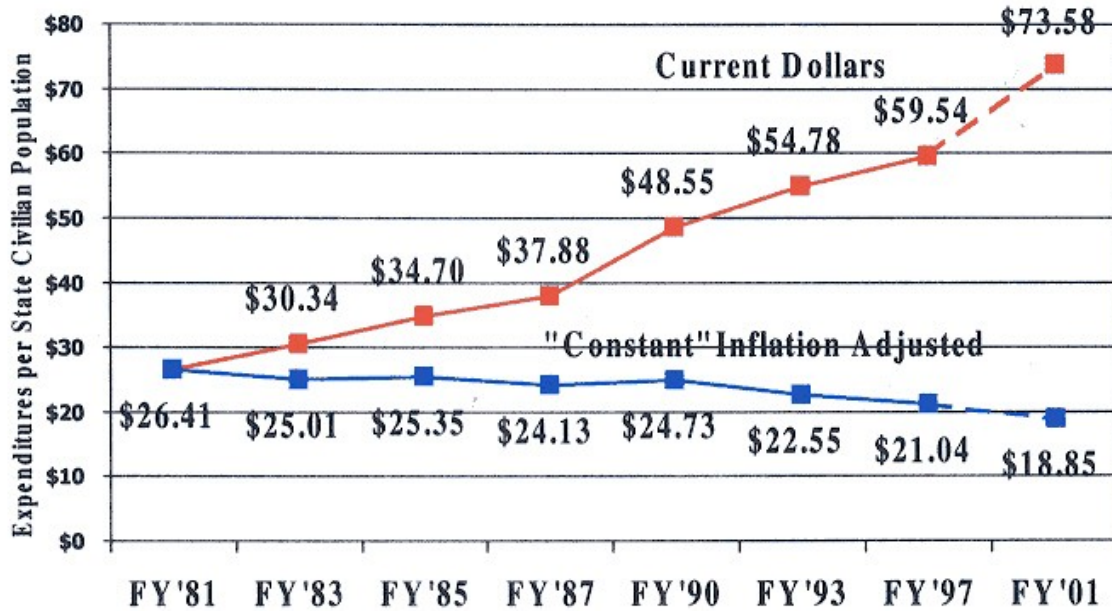
These brief examples are intended not as an exhaustive list of barriers to effective mental health service delivery, but as illustrations of the need for federal and state policies that work across systems and agencies to support the multiple and complex needs of individuals with mental illnesses. While successful implementation of these policies likely would require additional federal resources, we emphasize that much can be accomplished by ensuring that all federal agencies understand that their success or failure will be measured, at least in part, by their ability to effectively support the public mental health system and the individuals they serve. Again, thank you for the opportunity to testify today. We look forward to a constructive, collaborative dialogue between this Commission and state mental health agencies.

**Chart A: SMHA-Controlled Expenditures for State  
Psychiatric Hospital Inpatient and Community-Based Services as a  
Percent of Total Expenditures:  
FY'81 to FY'01**



Preliminary FY 2001 SMHA Revenue/Expenditure data based on early results from 44 States.  
Final Results with data from all 50 States will be available in the Fall of 2002.

**Chart B: Trend in State Mental Health Agency Controlled Per Capita Mental Health Spending, Current and "Constant" Inflation Adjusted, FY'81 to FY'01**



Preliminary FY 2001 SMHA Revenue/Expenditure data based on early results from 44 States.  
 Final Results with data from all 50 States will be available in the Fall of 2002.  
 Source: NASMHPD Research Institute, Inc., compiled under contract with CMHS. July 2002