Statement of Brian Hepburn, MD, Executive Director of the
National Association of State Mental Health Program Directors

before the Senate Health, Education, Labor and Pensions Committee

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Chairman Alexander, Ranking Member Murray, and members of the Senate HELP Committee –

Thank you for the opportunity today to address the Senate HELP Committee on state services for individuals with mental illness. And our thanks go to this Committee and its members, and other members of Congress in the Senate and the House, who are working to find ways to support, strengthen, and augment the country’s mental health care delivery system through legislation. Thanks especially to the Chair and Ranking Member for their own Mental Health Awareness and Improvement Act, Senators Cassidy and Murphy for their Mental Health Reform Act, and Senators Franken and Cornyn for their Comprehensive Justice and Mental Health Act. We are also appreciative of the full Congress passing Senator Cardin’s Improving Access to Emergency Psychiatric Care Act and approving the additional moneys provided in the Fiscal Year 2016 budget for the Mental Health Block Grant.

The organization which I represent, the National Association of State Mental Health Program Directors (NASMHPD), represents the state executives of the State Mental Health Agencies (SMHAs) responsible for the $41 billion public mental health service delivery systems serving 7.3 million people annually in 50 states, 4 territories, and the District of Columbia.

Prior to becoming NASMHPD’s Executive Director in July 2015, I served 13 years as Maryland’s Mental Health Program Director. I have also been a practicing psychiatrist.

The NASMHPD mission is to work with states, federal partners, and stakeholders to promote wellness, recovery, and resiliency for individuals with mental health conditions or co-occurring mental health and substance related disorders across all ages and cultural groups, including youth, older persons, veterans and their families, and people under court jurisdiction.

In collaboration with states, federal partners, and stakeholders, NASMHPD works to promote:

1. Prevention and Early Intervention

2. Integration of behavioral health care (both mental health and substance abuse disorder treatment) with physical health care
3. Trauma-Informed approaches to care across sectors, with civilians, veterans, and those in the correctional system

4. Models and interventions that minimize contact with police, the courts, and correctional facilities

5. The development and sustainability of an effective Behavioral Health Workforce

6. The availability of supportive employment and supportive housing, and a reduction in homelessness for individuals with mental illness and or addictions. The use of data and Health Information Technology to improve the quality of mental health services.

The SMHAs vary widely in how they are organized within each state government, how they pay for and organize their mental health service delivery systems, and their fiscal and staffing resources. However, all SMHAs share some common functions:

- Planning and coordinating a comprehensive array of mental health services with other state government Medicaid, correctional, educational, judicial, housing, and employment agencies, as well as local health and substance use disorder agencies, to meet the mental health treatment needs of individuals in their state;
- submitting an annual comprehensive community Mental Health Block Grant (MHBG) plan to the Substance Abuse and Mental Health Services Administration (SAMHSA), and monitoring, collecting data, evaluating, and reporting to SAMHSA on the performance and outcomes of systems funded by the MHBG;
- educating the public about mental illness and supporting public health prevention activities for mental health; and
- operating inpatient services units that provide critical intensive treatment for individuals with high levels of need or who are at risk of harm to themselves or others—including individuals involuntarily committed by the courts—in public psychiatric hospitals or psychiatric units in general hospitals and/or, increasingly, funding inpatient psychiatric services in private psychiatric hospitals or psychiatric units of private general hospitals.

In all of these functions, the SMHAs work closely with SAMHSA, which provides needed technical assistance and identifies and funds peer-reviewed, evidence-based practices to meet consumer needs. SAMHSA has been an excellent partner. Acting Administrator Kana Enomoto is a respected leader in the field, with a strong clinical background. We appreciate the opportunity to have her as a leader and partner.

SAMHSA has provided strong leadership in promoting best practices for the severely mentally ill. The practices championed by SAMHSA and adopted by the states have included crisis services
and crisis intervention teams and training and peer support services, as well as practices aimed at preventing suicide—such as the Zero Suicide initiative—and reducing homelessness, helping veterans find mental health and other supportive services, and addressing child and adolescent mental health through early intervention. In each of these programs and practices, SAMHSA and the states focus on promoting a recovery-oriented and person-centered system of care that empowers consumers in their decision-making and enables them to receive services in the least restrictive and most integrated setting.

The role of SMHAs has changed over the past 30 years. They have moved from primarily running state hospitals and directly providing services to increasingly focusing on community services. Thirty years ago, the funding for state hospitals was two-thirds of state mental health budgets and community funding was one-third. That has now flipped, so that funding for community services is two-thirds and the state hospitals are one-third of state mental health budgets. The majority of admissions to state hospitals 30 years ago were civil admissions of uninsured individuals. Now, most states have moved the civil admissions to private hospitals and the state hospitals are increasingly used for court-related admissions. In addition, most states are now contracting with the private sector to provide the direct services in the community.

It is also worth noting that 60 percent ($24.8 billion) of SMHA funding comes from state government revenues. The Federal Medicaid program is the second largest payer of SMHA mental health services (29 percent of SMHA funds, or $11.9 billion), followed by Medicare (1.7 percent). The MHBG constitutes just 1 percent of SMHA funding. MHBG funding—totaling $450.4 million in FY 2015, varies widely by state under a consumer-based formula; in FY 2015, state MHBG moneys ranged from California’s $63.1 million to Wyoming’s $535,764.

Among the effective, evidence-based practices identified and promoted by SAMHSA through its National Registry of Evidence-Based Programs and Practices (NREPP) are those intended to address First Episodes of Psychosis (FEP). Recognizing the demonstrated effectiveness of FEP pilots funded by the National Institute for Mental Health (NIMH) since 2008 in reducing incidences of untreated mental illness, Congress for the first time in FY 2014 designated 5 percent of all MHBG moneys—and increased grant funding accordingly—for programs that address first episodes of serious mental illness, including projects based on NIMH’s RAISE (“Recovery After an Initial Schizophrenic Episode”) FEP model operating in states such as Connecticut, New York, and Maryland. For this Fiscal Year 2016, Congress has increased the block grant set-aside for FEP initiatives to 10 percent, again increasing block grant funding to cover the expanded set-aside.

States have also become increasingly involved in working with consumer advocates, peer support workers with lived experience, providers, and state insurance divisions to see that insurers comply with the Federal mental health and addiction parity mandates enacted in 2008 and 2010. Full compliance is still a work in progress, but NASMHPD is convinced that continuing education and monitoring of insurers by providers, consumers, and state agencies should eventually ensure
that mental health and substance use benefits are subject to no restrictions—quantitative or non-quantitative—greater than those imposed on surgical and medical benefits.

As increased MHBG funding continues to be made available to the states by Congress, the states should be able to effectively grow their FEP services and the other community-based services for which payers and payment are scarce, such as crisis services, wraparound services, supported housing and supported employment, and ACA enrollment outreach. NASMHPD’s members are grateful for the assistance provided so far, and we look forward to continuing to work with SAMHSA and Congress in developing a continuum of evidence-based mental health care and services for each community.

What are some additional actions that Congress and the Administration could take to support the State Mental Health Authorities?

- **Continue to support the set aside for First Episode Psychosis programs, but consider changing the allocation methodology so that states with smaller consumer populations and thus smaller block grants, like Rhode Island, Alaska, Maine, Vermont, Wyoming, North Dakota, and Delaware, may receive an amount sufficient to fully implement a working FEP program.**

- **Modify the Medicaid Institution for Mental Disease (IMD) exclusion so that IMDs are able to receive Medicaid funding for adults.**

- **Reauthorize the Medicaid Money Follows the Person program, due to expire September 30, which states such as Texas are using to help fund behavioral health services for individuals in home- and community-based settings.**

- **Support the Zero Suicide goal. The National Suicide Prevention Lifeline, with funding from SAMHSA under the Garrett Lee Smith Act, has developed an excellent hotline system across the country, linking callers with needed crisis services.**

- **Encourage the use of technology for mental health through reimbursement by Medicaid. As stigma has decreased and more persons are seeking mental health services, there is a workforce and access problem. Technology such as telehealth may be able to help with both. Internet services help to reach underserved rural, urban, and frontier areas.**

- **Support targeted efforts for smoking cessation in persons with mental illness. Persons with Mental illness die at a much earlier age than the general population. This is primarily due to smoking.**

- **And, finally, support parity by strengthening monitoring and enforcement mechanisms.**

Thank you for your attention to and consideration of this testimony.