

Mental Health in America: Where Are We Now?

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Statement by Linda Rosenberg, MSW

President and CEO

National Council for Behavioral Health

Thank you to the members of the Committee for inviting me to be with you today. On behalf of the National Council for Behavioral Health, I appreciate the opportunity to talk with you about the challenges and opportunities facing our mental health system.

Last week, the Centers for Disease Control and Prevention released data showing a steady growth in suicide rates in the U.S. each year since 1999, increasing by 25 percent in the last 15 years. Deaths by suicide are rising among adolescents and youth... among middle-aged Americans... and among older adults.

This news was especially difficult for me because I serve on the Executive Committee of the Action Alliance for Suicide Prevention. Despite growing attention to the issue of suicide prevention, our nation hasn't been able to move the needle. Shining the spotlight of public attention into the shadows of mental illness is not enough.

There is rising public attention everywhere we look. This week, the New York Times featured a story about the Portland Police Department's efforts to improve how they handle crises. As Portland's police chief put it, "we are working in the backdrop of a fractured mental health system that has gotten worse and worse."

Talk of mental health and addictions has reached the presidential campaign trail, where candidates are making the issue a major platform of their campaigns. Governor Kasich, whose brother has been diagnosed with schizoaffective disorder and whose home state of Ohio saw more than 2,700 residents die of a drug overdose in 2014, has called for more services. And on the other side of the aisle, Hillary Clinton has released a comprehensive plan to address treatment and recovery.

600,000 Americans have taken a Mental Health First Aid course. The public is hungry to learn how to recognize the signs of mental illness, to be able to respond in an emergency, and to know where you can get help. Teachers, first responders, veterans, clergy, construction crews – the demand continues to grow.

So, yes – everyone – from Portland cops, to the candidates for President, to friends and colleagues – is talking about mental health and addictions. But as the numbers show, it is not enough. It's not enough for the more than 41,000 Americans who died by suicide last year. It's not enough for the more than 28,000 who died from an opioid overdose.

It's not enough, but not because of stigma, and not because we don't know what works in preventing these tragic deaths. It's because of how rarely those interventions are available – across settings – to reach people in their moment of need.

Life-saving treatments are too often delivered through federal, state or local grants. When patients have cancer or heart disease, getting access to chemotherapy or a stent doesn't depend on their local clinic having a grant that targets those conditions. Treatment for mental illness and addiction should be no different.

Today, Congress has the opportunity to change the course of millions of lives. The question before you is not, "where are we now?" but "where do we need to be?" To get there, we need to move from talk to action: from raising awareness to connecting people with help. Here's how we can do it:

- **Access:** Expand access to a full continuum of services delivered in the context of robust and sustainable community-based delivery systems.
- **Science-based care:** Invest in evidence-based services, delivered by a skilled workforce that leverages technology and is held accountable for outcomes.
- **Integration:** Ensure mental and physical health care is integrated, services are coordinated, and high-need, high-cost populations are targeted.

Access. To answer the question of "where do we need to be?" let me begin with the issue of the shortage of psychiatric hospital and residential beds. Currently, the Medicaid Institutes for Mental Disease (IMD) exclusion makes it difficult for inpatient and residential facilities to expand. This has led to proposals to eliminate the IMD exclusion entirely or raise the permitted number of beds.

In some communities there is a need for more beds, and these inpatient facilities represent an important part of the spectrum of care. However, at their core, these services are designed to help people experiencing a sudden and severe deterioration of their health. Inpatient services will never be fully effective in a vacuum. Instead, they must be delivered in the context of a continuum of care. Only community-based services can prevent re-admissions, trauma, and disruptions to home and work. At a time when we are growing Accountable Care Organizations and Medical Homes, beds aren't enough.

That's why the National Council is so proud to support the Excellence in Mental Health Act, which enables and sustains quality community treatment systems, and facilitates the coordination of care across health care settings.

The Excellence Act demonstration established criteria for Certified Community Behavioral Health Clinics (CCBHCs) that provide mental health and substance use services and primary care screening – along with care coordination. When care in a different setting is needed, CCBHCs coordinate with that facility to ensure seamless transition into and out of care. CCBHCs must also collaborate with schools and justice systems to keep individuals out of jail, at work, and in school. In turn, organizations that meet the criteria to be a CCBHC qualify for a Medicaid reimbursement rate that supports expanding services, serving new populations, and engaging patients and families outside the four walls of their clinics.

The comprehensive array of services envisioned under the Excellence Act includes crisis services. There has been talk in policy circles about investing in crisis services, and for good reason: timely access to high-quality crisis care can be the difference between an individual getting the intervention they need and that same individual ending up in the emergency room, jail, or worse.

This is not the first time crisis services have gained prominence in our policy debates – they were also touted in the 1980s as a way to alleviate the burden on overcrowded, understaffed hospitals. Crisis respite centers opened but many, funded by grants, struggled to survive. And, just as with psychiatric hospitals and residential facilities, standing alone, they were not enough.

The integration of crisis care into broader community-based delivery systems is a cornerstone of the Excellence Act, with CCBHCs required to directly deliver 24-hour crisis care (including mobile teams). CCBHCs must also coordinate with law enforcement and criminal justice agencies to ensure they're supporting public safety officers who too often are first responders to a psychiatric crisis.

Importantly, CCBHCs must also coordinate with veterans-serving agencies. As members of our armed forces return from Iraq and Afghanistan, rates of post-traumatic stress disorder and traumatic brain injury are on the rise. Unfortunately, too many veterans cannot access the services they need, in some cases because VA facilities are overburdened or simply inaccessible. CCBHCs are tasked with providing culturally competent care to veterans and members of the armed forces, and are responsible for coordinating that care with other agencies that serve veterans.

The integration of crisis care with community-based care envisioned in the Excellence Act could transform the way people access crisis services in this country – it could quite literally save lives. Unfortunately, it won't be available to all Americans.

Under the Excellence Act demonstration, twenty-four states are currently planning the comprehensive mental health service reforms that will allow them to certify, pay, and monitor CCBHCs. Yet, the law sets an 8-state limit on those who may ultimately participate – meaning that two-thirds of the planning states will have to stop in their tracks. Every state that wishes to create and sustain quality service systems should be able to do so, and that's why the National Council urges you to allow all 24 states to participate in the demonstration.

Science-based care delivered by a skilled workforce with the support of technology. To get our nation's mental health and addiction services to where they need to be, it's not enough to expand access – we must ensure that services are high-quality, evidence-based and delivered in a way that both enables us to measure what's working (or what isn't) and holds us accountable for outcomes.

Unfortunately, the adoption of practices based upon the best available research is limited by a reliance on grants. For example, recent data from the NIMH Recovery After an Initial Schizophrenia Episode (RAISE) study showed the effectiveness of a multi-pronged intervention for individuals experiencing their first episode of psychosis. The intervention included evidence-based practices such as cognitive behavioral therapy along with medication, family psychoeducation, case management, supported education and employment. Despite research here in the U.S. and around the world, and the allocation of block grant funding, it's not enough. Most communities will be unable to implement the requisite interventions and tens of thousands of young people will be relegated to a life of disability.

Certified Community Behavioral Health Clinics hold the promise of expanding Americans' access to science-based care. CCBHCs are required to offer evidence-based services to meet the specific needs of their communities – and they can be paid a rate inclusive of these activities. Through data tracking and

outcome monitoring, clinics will be held accountable not just for delivering these services, but for measuring patients' progress and adjusting course when treatments aren't working as hoped. Clinics that do well will be rewarded with quality bonus payments, another step in our nation's move toward linking payment with performance, toward much discussed value-based purchasing.

But a key challenge to delivering timely, high-quality services lies in our nation's shortage of mental health and addiction treatment professionals. The behavioral health workforce needs additional capacity and support to fully meet Americans' need for services. Texas, Iowa, Indiana, Idaho Nevada and Wyoming all have fewer than six practicing psychiatrists per 100,000 people – in fact, a mere 34 psychiatrists practice in the entire state of Wyoming. Just last week, I spoke with a medical director at a clinic in Texas who has been trying for more than three years to recruit a child psychiatrist. His situation isn't unique. Clinics all over the country struggle to recruit and retain staff.

One way Congress can help is by permitting licensed mental health counselors and marriage and family therapists to directly bill Medicare for their services. Technology can also help, playing a crucial role in extending the workforce. Using state-of-the-art streaming video technology, staff can connect with patients to adjust medications, deliver cognitive therapies, and educate and support children and parents. Online treatment platforms such as myStrength help patients manage in their daily life. Mental health and addiction organizations can be helped to adopt electronic health records – a proposal that has received strong bipartisan support – to better track patient outcomes, facilitate the exchange of health information, and coordinate care.

But the fundamental limitation underlying all discussions on the workforce is that most clinics cannot afford skilled staff or the necessary ongoing investments in technology. Those of you on this panel who have ever run a business know this is unsustainable – and it's no way to successfully treat Americans with mental illness and addictions. If we are ever going to alleviate the workforce shortage, we need clinics to be able to afford to hire the right staff and pay them what they deserve. And we need sustainable financing mechanisms that reimburse providers at a rate inclusive of technology costs.

The Excellence Act demonstration offers certified clinics a Medicaid payment rate that bears a rational relationship to the costs they incur. Under the Excellence Act, clinics will be able to hire critical staff – including psychiatrists, midlevel professionals and peers – and leverage new technologies to further extend the reach of those clinicians. They will be able to do this because they will receive a sound, predictable and sustainable payment rate that – unlike grant funding – supports the full array of activities of a high-performing clinic and does so in a way that will continue into the future.

Integration. Data show that individuals with serious mental illness have an average age of death at 53, the same as the U.S. life expectancy in 1917. The primary drivers of that early mortality are preventable and/or treatable chronic conditions like heart disease, lung disease, and cancer. Data also tells us that people with chronic physical illnesses often have co-morbid mental illnesses, especially depression and anxiety, that lead to poor health outcomes. Integrated care improves outcomes for both groups.

Earlier this month I had a first-hand experience with integrated care. On a Sunday, I went to an urgent care clinic. Unbeknownst to me, that urgent care clinic was part of an Accountable Care Organization that also included my primary care physician – which I discovered upon showing up at her office on Monday and

finding out that they already knew all about the problem that had brought me to urgent care! They had access to my electronic health record and knew what treatment I had received. When my primary care doctor ordered a sonogram, the ACO followed up with a phone call asking if I'd like to use their sonogram provider. That's smart business AND it's good care. The two can, in fact, go together.

Unfortunately, my experience is still all too rare. Far too few health care organizations are equipped to fully coordinate and integrate care in such a way that every patient could reap the benefits I did. But behavioral health is aware of the need to better integrate care, and we are at a tipping point. The Excellence in Mental Health Act, through its creation of CCBHCs, represents a foundational opportunity in the behavioral health safety net to advance the way care is integrated and coordinated.

CCBHCs are required to provide basic primary care screening and monitoring to all their patients, with referrals to and coordination with local primary care providers. In this way, they help reverse the trend of early mortality due to preventable causes among people with serious mental illness; and help primary care providers better address their own patients' ongoing mental health needs.

We know through the SAMHSA Primary Care-Behavioral Health Integration program, which has been funded by Congress since 2009 and has served over 70,000 Americans, that investing in integrated care improves health and reduces costs. For example, after one year in the PBHCI program, results from one grantee site in Travis County, Texas indicated patients had 618 fewer emergency room visits and spent 155 fewer days hospitalized. These outcomes resulted in \$1,193,000 saved in a year.

These results were from one clinic operating under a time-limited grant. Just imagine what we'll see when the Excellence Act demonstration's CCBHCs start their operations in January of next year.

Conclusion. The question before you is not, "where are we now?" but "where do we need to be?" Shining the spotlight of public attention into the shadows of mental illness is not enough. We need to move from talk to action and from pockets of excellence to the widespread availability of effective interventions.

The Excellence in Mental Health Act – CCBHCs – is where our mental health system needs to be – financially sustainable continuums of evidence-based treatments supported by and integrated with primary care, 24/7 high-quality crisis services, and a revitalized behavioral health workforce. That's what we can call reform.