Testimony of Representative Patrick J. Kennedy
Senate Health, Education, Labor, and Pensions Committee
"Transforming Mental Health Systems of Care: Community Integration and Recovery"
May 8, 2007

Senator Reed and Senator Enzi, thank you for inviting me to testify today. Senator Reed, I'd like to particularly commend you on your leadership in this hearing. While I'm very fond of the committee chairman, I'm also proud to have a fellow Rhode Islander holding the gavel today, and exhibiting a strong voice for improving mental health and substance abuse care every day.

When you get right down to it, we do a terrible job delivering mental health and substance abuse care in this country. This is not a knock on the providers, who are for the most part paid a pittance and are truly doing the Lord's work with little thanks. It's also not a knock on SAMHSA. The people there are dedicated and swimming hard upstream in a culture and government that undervalues mental health and substance abuse treatment, trying to improve care and create change.

The fact is, however, most people in need of treatment don't get it. Those who do often don't get the benefit of the latest science. Care for mental illnesses and substance abuse is segregated, often nearly entirely divorced from the rest of health care and even from each other.

Every few years, it seems, there's another blue ribbon report on the challenges we face on mental health and substance abuse. The Surgeon General's report in 1999. The New Freedom Commission report in 2003. The Institute of Medicine report in 2005. The focuses of these reports differ, but the underlying message of all are consistent: in the words of the New Freedom Commission, "the mental health services system does *not* adequately serve millions of people who need care."[1]

Congress's goal for reauthorizing SAMHSA should be to ensure that the agency can be a force for transforming our fragmented and broken mental health and substance abuse treatment systems. We need to be thinking systemically, and asking what levers we can pull that will change the underlying dynamics of the mental health and substance abuse systems.

With that perspective in mind, I would suggest three overarching themes for our focus: 1) driving the development and use of the evidence base; 2) dramatically improving the coordination of mental health, substance abuse, and primary care; and 3) expanding our investment in prevention.

<u>Developing and Using the Evidence Base</u>

There are several interrelated problems when it comes to the evidence base. At a systems level, we remain set up to deliver care that is more expensive, inpatient-oriented,

[1] President's New Freedom Commission on Mental Health, *Interim Report to the President* (2002), p. 1.

and in response to crises rather than a community- and family-based, recovery-oriented model of service delivery. We know that doesn't produce the best outcomes and certainly is not a good use of scarce resources, yet we inhibit the evidence-based approach to care delivery.

Another problem is that far too often providers don't use the science we have. The IOM's report on Improving the Quality of Health Care for Mental Health and Substance-Use Disorders, a number of studies have documented the failure of clinicians to adhere to evidence-based care guidelines for a wide range of disorders. Overall, in only 27% of studies were adequate adherence rates found.[2]

A third problem is that the research is often not directly relevant to real-world practice. Participants in trials are often screened out to ensure they don't have co-occurring disorders or other complicating factors, and most trials take place in academic medical centers, not at the community based treatment centers where so much care actually occurs. As in the rest of health care, we invest very little in comparative outcomes research and services research, to discover which interventions are more cost-effective, and how to most effectively and safely deliver care.

While the solutions to these problems go beyond SAMHSA, there are some important steps we can take to build the development and use of the evidence base into our mental health and substance abuse treatment systems.

First, we need to support SAMHSA's efforts in recent years to help states transform antiquated systems. For years we have known that community-based systems of care produce better outcomes at a fraction of the cost of institution-based systems. In Rhode Island in 2000, a year in residential treatment for an adolescent cost $242,000, a year in the Training School cost $94,000, and a year of intensive, community-based services cost $14,000.[3] SAMHSA made a few rounds of transformation grants to help states move to a more modern approach, but has been unable to implement those fully as the budget has been squeezed. The problem in many states is that the transition cannot happen all at once. Creating new treatment options carries a cost, but does not allow the state to immediately stop paying for beds it is carrying. We need to figure out ways for SAMHSA to support the transition, while ensuring that the funds carry accountability for changes to evidence-based systems of care.

On a related note, we should expect more of states that have received Children's System of Care grants. These grants have produced islands of excellence in local communities, but are too often not sustained and not brought to scale. The program has been highly successful, but should be tweaked to ensure greater involvement and buy-in from the state and incentives to replicate local successes in other communities and statewide.

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[2] Institute of Medicine, *Improving the Quality of Health Care for Mental Health and Substance-Use Disorders* (2005), p. 133.
[3] Rhode Island Public Expenditure Council, *A Review of the Department of Children, Youth and Families* (2001), p. 32.

Next, I propose the creation of a permanent Commission for Evidence-Based Mental Health and Substance-Use Health Care. This expert panel would be responsible for strengthening, consolidating, and coordinating the synthesis and dissemination of evidence-based best practices.

This non-political commission would build on work being done at SAMHSA, as well as at AHRQ and NIH. The Commission would be able to provide a "good housekeeping seal of approval" to prevention, screening, diagnosis, and treatment practices supported by science and to create a research agenda by identifying areas where strong evidence is lacking.

By benchmarking evidence-based practices, the Commission could provide guidance to the field to focus training and professional development. It would also allow for the development of performance measures that can, over time, enable pay-for-performance and other value-based purchasing strategies that are the most important means of improving care. Because the research base is thin in many areas, we need to be very careful not to go too far too quickly in linking payment to the use of evidence-based practices – we do not want to shut down access to effective interventions that may not have been adequately researched yet. But ultimately, payment drives practice patterns, and if we want to better use the evidence base and get better outcomes and a more efficient use of resources, we need to adjust how we pay for care.

A complement to payment-based strategies for improving the quality of care is better direction by the professions themselves. This field is marked by a large number of different professions, with a wide range in terms of training, credentialing, and licensure. There is little consistency or quality control across mental health and substance abuse treatment.

We should heed the Institute of Medicine's recommendation to create of a Council on the Mental Health and Substance-Use Workforce, to parallel councils for physicians and nurses. This new council would provide guidance to graduate schools and state licensing bodies to ensure that professionals working in the field have appropriate expertise grounded in the latest science and that consumers have meaningful information about providers when seeking out care. This group could also provide an ongoing assessment and data to back up the widespread anecdotal reports of critical workforce shortages in the field.

Finally – and this may be a bit further afield for a SAMHSA reauthorization bill – I believe we need to create a national network of mental health and substance abuse centers of excellence, akin to the national centers of excellence in cancer. We need to tie our cutting edge, institution-based research to community-based practice settings, and make a national commitment to finding new cures and treatments. While there's been an explosion in understanding of these diseases due to brain scanning technology and genomics, we are still essentially using variations on the same treatments we had thirty years ago. I would like to see a major initiative that can dramatically expand the

evidence base, building on and tying together the work that is happening at leading institutions like Brown, the University of Michigan, UCLA, and UC-Davis. I have spoken to leading researchers around the country and believe that the time is right for a national network that could be greater than the sum of its parts.

Dramatically Improving the Coordination of Care

Just last week USA Today ran a front page story on a new report that shows that individuals in the public mental health system die, on average, twenty-five years earlier than the general population.[4] This shocking outcome is not based on suicide, mind you, but on poorly managed general health and other chronic diseases like diabetes and heart disease.

Part of the explanation may lie in the comorbidity of mental illnesses and smoking or the side-effects of medications commonly taken by people with mental illnesses. Undoubtedly, however, a major contributor is the poor coordination between primary health care and mental health and substance abuse care. The problem is severe even within behavioral health, as mental health and substance abuse care are often siloed, even though the patients are so often the same people.

The federal government bears a chunk of the responsibility, and one thing we should seek to do with this reauthorization is to take down some of the barriers that we erect between primary care, mental health care, and substance abuse care.

I am well aware of the historical factors at play in this space, and that even talking about better integrating mental health and substance abuse treatment makes some people's hair stand up on end. But I am also aware that research unambiguously shows that individuals' outcomes are better when care is coordinated and, ideally, integrated. And I believe that there are steps we can take that would help without upending our current patterns.

For example, it is currently very difficult to use either mental health or substance abuse treatment block grant funds to pay for truly integrated care for co-occurring disorders. That's because the block grants carry strict requirements on paying only for mental health or substance abuse respectively, so documentation problems arise when the care is integrated. Without opening the door to merging the block grants, it should be possible to enable providers -- or even better, to encourage them -- to deliver the most effective, integrated care to individuals with co-occurring disorders.

Similarly, I would like to see ways of encouraging our community behavioral health centers and community health centers to collaborate. We spend enormous sums on two parallel systems of community health providers. But because one is funded out of HRSA and the other out of SAMHSA, their collaboration is haphazard at best. Imagine if instead centers were co-located. Or even that whenever a person contacted a community behavioral health center for an appointment, they were also given an appointment at the community health center to check their other chronic diseases. We should build

[4] Marilyn Elias, "Mentally ill die 25 years earlier, on average." *USA Today* (May 3, 2007).

incentives into these funding streams to bring about partnerships that will bring people's care together.

Of course, these kinds of disconnects exist throughout various government programs. The federal government should get its own house in order, and begin collaborating around mental health and substance abuse, so it can ensure that collaboration occurs where services actually meet consumers.

One such success story is the Safe Schools Healthy Students program (SSHS). In 2001, then-Surgeon General David Satcher came to Rhode Island for a forum I put together on children's mental health. Surgeon General Satcher singled out SSHS as the most successful program he had seen in mental health. Now remember, this is just a year after his groundbreaking mental health report. What distinguished SSHS, he said, was that it was a genuine partnership between SAMHSA, the Department of Justice, and the Department of Education, and their counterparts at the local level. Because the three federal departments developed and funded the program together (at least in the early years), it was able to require and get real buy-in from the police departments, schools, and mental health agencies and was therefore extremely effective.

SSHS should be a model for us. We should create an ongoing behavioral health working group among various HHS agencies, VA, DOD, DOJ, Education, and perhaps even HUD and Labor. The mandate of this group should be to ensure that programs for mental health and substance abuse treatment do not conflict with each other and to foster collaboration in the delivery of services. We should ensure that the agencies have authority to pool their funds for interagency grants like SSHS was initially. Until our own federal government gets its house in order, we cannot realistically expect our systems to regularly deliver the kind of coordinated care consumers need and deserve.

Expanding our Investment in Prevention

With so much unmet need for treatment, it is difficult to carve out funding for prevention. Still, we all appreciate how frustrating, absurd, and inefficient it is to be waiting for people to crash when we have some ideas about how to keep them healthy in the first place.

I would begin with a much more robust investment in the most vulnerable children from birth to six. The fact is, we know which children are most likely to be abusing drugs and alcohol or wind up with mental health problems when they are older. We know them by behaviors – just ask any kindergarten teacher which students are heading for trouble – and we know them by environmental factors. The research clearly shows that kids living in homes with maternal depression, substance abuse, and family violence are much, much more prone to developing problems of their own. There are actual, physical changes to their brains that occur as a result of the toxic stress levels that they are subjected to.

We also know how to have the greatest impact on those children and set them on more healthy trajectory: work with the family. There's some fascinating research out of

the NYU Child Study Center's Parent Corps program. They worked with the parents only, no intervention with the children. After intensive lessons and guidance in parenting and such things as discipline, dealing with crying babies, and the like, the program produced measurable changes in the children's brains – physiological changes in the children as a result of working solely with the parents. And we know from studies like the Perry Preschool Study that intervening early can change outcomes for life. For example, at age 40, participants in that study were 50% more likely than their counterparts to be earning $20,000 per year, 44% more likely to have graduated high school, and 53% less likely to have been arrested five or more times. The investment in these young children's lives has thereby paid off annualized internal rate of return of 18% in additional tax revenues and expenditures saved.[5]

The Starting Early Starting Smart program, an innovative joint venture of the Casey Foundation and the Center for Substance Abuse Prevention at SAMHSA, was a family- and caregiver-focused approach to working with vulnerable children, using child care providers and pediatricians as the entry point. Unfortunately, it was conducted as a research demo, and allowed to peter out. We should resurrect that approach. SAMHSA's commitment to prevention should include a significant investment in young children with multiple risk factors and in their families.

We also should bring a stronger prevention ethos to school-based behavioral health. Approaches based on positive behavioral supports that help improve all students, provide early identification for students in need of formal assessments, and services along a continuum can prevent students from falling through cracks and reaching crises before their needs are recognized or met. In partnership with the Department of Education, SAMHSA should work to broaden the role of school-based mental health personnel as well as expand collaborative programs such as SSHS.

Conclusion

There is no shortage of priorities in the mental health and substance abuse fields. In addition to the issues discussed above, there are plenty of other things that should happen in a reauthorization of SAMHSA: fostering the use of information technology and ensuring that the mental health and substance abuse field is integrated into the larger health IT systems being developed; reauthorizing the Garrett Lee Smith Act; codifying a program to focus on the mental health and substance abuse treatment needs of seniors; authorizing the Keeping Families Together Act; and developing performance measure at both the systems and provider levels are just some of the priorities that should be included.

That said, we also must acknowledge the two major limitations on this bill: first that Medicaid, much more than SAMHSA, is driving the direction of the mental health system today (and currently, in the wrong direction, away from a recovery model), and secondly, that SAMHSA is and will continue to be for the foreseeable future woefully underfunded.

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[5] Lawrence J. Schweinhart, Ph.D., *The High/Scope Perry Preschool Study Through Age 40: Summary, Conclusions, and Frequently Asked Questions* (2005).

Given those two realities, I believe we really must think strategically about how we use SAMHSA's resources. While there are many terrific grant programs, a number of which I strongly advocate for in the Appropriations Committee every year, the fact is that with its limitations, SAMHSA is much better off leveraging systems change than funding services. As we move forward, I would urge the committee to think carefully about how a reauthorized SAMHSA can put in place infrastructure, systems, and incentives that will drive long-term, lasting change in the way care is delivered.

Thank you for the privilege of testifying today. I look forward to working with you to bring more accessible, higher quality, and more efficient mental health and substance abuse care to all Americans. Thank you.

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