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 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, Senators Cassidy and Murphy, and Senator Franken for their comprehensive legislative approaches to assisting the mentally ill. We also appreciate the full Congress passing Senator Cardin's legislation to extend and expand the Medicaid IMD Demonstration and its approval of the additional moneys provided in the Fiscal Year 2016 funding for the Mental Health Block Grant (MHBG) set-aside for early intervention.

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 the states, territories, and D.C.

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's members work 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 with civilians, veterans, and those in the correctional system;
4. Models and interventions that minimize consumer 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; and
7. The use of data and Health Information Technology to improve the quality of mental health services.

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 in 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 Medicaid, correctional, educational, judicial, housing, and employment agencies, as well as local health and substance use disorder agencies;
- submitting an annual comprehensive community Mental Health Block Grant (MHBG) plan to the Substance Abuse and Mental Health Services Administration (SAMHSA), and then reporting to SAMHSA on performance and outcomes;
- educating the public about mental illness and supporting public health prevention activities for mental health; and

- operating or funding inpatient services for individuals with critical levels of need—including individuals involuntarily committed by the courts—in public or private psychiatric hospitals or psychiatric units in general hospitals.

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

SAMHSA has provided strong leadership in promoting best practices for the severely mentally ill. The practices 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. With Congressional funding of what is now a 10 percent mental health block grant set-aside for First Episode Psychosis services, we have been able to focus increased attention to serious mental illness at its earliest stages, in order to prevent the deterioration in cognitive ability which accompanies repeated episodes of psychosis.

It is important to note that the role of SMHAs has changed over the past 30 years, from primarily running state hospitals and directly providing services to increasingly focusing on community services provided in partnership with the private sector. Thirty years ago, funding for state hospitals was two-thirds of state mental health budgets and community funding was one-third. That is now reversed. 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.

It is also important to note that 60 percent of SMHA funding comes from state government revenues. The Federal Medicaid program is the second largest payer of SMHA mental health services at 29 percent, with the MHBG constituting 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.

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 can receive an amount sufficient to fully implement a working FEP program.

- Modify the Medicaid Institution for Mental Disease (IMD) exclusion so that IMDs can receive Medicaid funding for adult stays.

- Reauthorize the Medicaid Money Follows the Person (MFP) 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 more persons seek mental health services, there is an ever-increasing workforce and access problem. Technology such as telehealth can help reach individuals in underserved rural, urban, and frontier areas.

- Support targeted efforts for smoking cessation in individuals with mental illness. Smoking is the primary driver for the higher mortality rate among individuals with mental illness.

- And finally, support Mental Health and Addiction Parity by strengthening monitoring and enforcement mechanisms.

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