CENTERSTONE

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Senate Committee on Health, Education, Labor and Pensions Hearing:
Assessing the State of America's Mental Health System
January 24, 2013

On behalf of Centerstone, I would like to personally thank Senator Alexander and Senator Harkin for the opportunity to comment on the state of the U.S. Mental Health System from the community mental health perspective. I hope what I share will assist the Health, Education, Labor and Pensions Committee as you seek to gain an understanding of opportunities to address the gaps and barriers within our mental healthcare system.

To work in the area of community mental health is, without question, an extraordinary privilege. It is likewise a tremendous responsibility.

I have been fortunate throughout my career to participate in and observe our field from different perspectives—as a clinician, a critical incident responder, faculty member, research collaborator, client, and as a CEO. I have worked with hoarders whose homes were so cluttered that there was no longer safe passage to their beds for rest and refrigerators so contaminated that the contents were no longer safe to consume. I have worked with people who are so profoundly disturbed they've committed despicable and sometimes illegal acts. My role with these patients was to quell their psychosis and ensure safety for themselves and others. I also have had the responsibility of treating a mother's depression and complex grief following the tragic death of her preschool-aged child.

I have seen first-hand what the research shows – mental illness truly affects everyone. One in four American adults will have a diagnosable mental illness in any given year, and about one in 17 adults, 6% of the population, have a serious mental illness.[1]

As a community mental health center (CMHC), we are entrusted with the care of individuals, families, and communities whose lives have been impacted by mental illness. As health care leaders, we are called upon to work to create a mental healthcare system rooted in compassion, scientific understanding, individual recovery and, ultimately, disease management, prevention and cure.

I chose this field nearly four decades ago because I thought that effective treatment for mental illness could have an equal or even more profound impact on families than treatment for heart disease and cancer. In school, I saw my inspired, intelligent friends devastated by anxiety, depression and bipolar disorder. I witnessed how trauma could weaken even the strongest of my colleagues.

Over the years, I have found this to be true in my own family as well, especially when my forty-year old cousin, Lisa, took her own life. I wish she had been able to ask for help when her pain

[1] Kessler RC, Chiu WT, Demler O, Walters EE. Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). *Archives of General Psychiatry*, 2005 Jun; 62(6):617-27.

became unbearable because I know there is an alternative to senseless death. Mental health treatment is life-saving.

Role of Community Mental Health Centers

Community mental health centers have an incredibly important role to help provide effective, high quality care to the children, families, and older adults they serve. We help to keep children together with their families. We provide a lifeline for people struggling at all levels of severity of need, from mild levels of anxiety to acute episodes of depression to those contemplating suicide. Our treatment services and broad array of services for all ages, work to prevent horrible tragedies while helping to build strong, healthy, resilient communities. Community mental health centers, as a whole, fill a tremendous gap and, moreover, do a tremendous job for the people we serve. There are, nevertheless, several significant barriers and gaps in the current U.S. mental health system that make it difficult for our local agencies to serve as the community safety net they were envisioned to be 50 years ago by President Kennedy.

Barriers & Gaps in Access to high quality Child & Adolescent Services

One of the biggest barriers is a lack of access to services for children and youth. Sadly, due to a lack of a federal definition of what services a community mental center should offer, many towns and cities, especially rural ones, do not have access to a safety net provider, offering a full continuum of evidence-based services to children and youth within a service area. Since 50% of mental illnesses start before the age of 14, and three out of four people develop their condition, including bipolar disorder, depression and schizophrenia by young adulthood, this lack of access can have tragic, lasting effects.[2]

We know from the research that the right care at the right time has a huge potential to reduce the occurrence of mental illnesses, the severity of those illnesses, and their impact on people's lives. Early mental health interventions for young children and families can reduce risk factors for mental illness and increase protective factors that build resiliency.[3] If children impacted by multiple traumatic experiences do not get the care they need, it can have serious, life-long consequences.[4]

There are several ways to address this barrier:

- The most permanent fix would be to pass language similar to that included within the **Excellence in Mental Health Act** specifically defining that a community mental health center has to provide a full continuum of services across the lifespan – including early intervention services.
- **Grant funding streams** that encourage existing centers to expand their service continuum and partner with community organizations are also helpful. At Centerstone,

[2] Kessler, R. C., Berglund, P., Demler, O., et al. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey replication. Archives of General Psychiatry, 62, 593-602.

[3] National Research Council and Institute of Medicine. (2011) *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities*. Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults: Research Advances and Promising Interventions. Mary Ellen O'Connell, Thomas Boat, and Kenneth E. Warner, Editors. Board on Children, Youth, and Families, Division of Behavioral and Social Sciences and Education. Washington, DC: National Academies Press.

[4] Edwards VJ, Holden GW, Anda RF, Felitti VJ. Experiencing multiple forms of childhood maltreatment and adult mental health: results from the Adverse Childhood Experiences (ACE) Study. *American Journal of Psychiatry* 2003;160(8):1453–1460.

due to grant funding from SAMHSA and the Department of Education, we have been able to offer mental health and substance abuse services within rural schools for children and youth. We are now co-located in 160 preschools, middle and high schools throughout Tennessee, serving as adjunct faculty and providing a service to the school, they would likely be unable to deliver without our partnership. In addition, we recently were awarded a grant for early intervention services for families of infants and toddlers at risk for emotional problems

- Pass **Health IT legislation** so that community mental health centers, especially rural centers, can access telehealth services. With a severe and growing national shortage of child, adolescent, and adult psychiatrists,[5] telehealth is one of the key ways to foster improved access to services for children and adults with serious mental illness, especially in underserved and rural areas.

Barriers to engaging the whole family in care.
For our children, the most effective care involves treating the entire family. Over and over, my staff, who work with children in schools and other community settings, share frustrations and concerns for the children they treat because of limited or entirely no access to the child's parents or caregivers. So often we detect issues in parents and other people in the child's environment, yet we are sometimes hindered in our ability to treat the entire family unit due to inadequate insurance coverage.

There are barriers to treating their uninsured or underinsured parents who have their own mental health needs and issues. We need to be able to teach parenting skills if we want the child's behavior to change. We need to be able to address the parent's depression or addiction if we want to make an impact on a child's anxiety, truancy, or aggression. A mother is only able to advocate for her child and coordinate care if she, herself is healthy and able to cope.

We are eagerly awaiting further news regarding a decision related to Medicaid expansion. It will allow community mental health centers to treat the low income parent's depression, substance use disorder, and/or other condition that impede effective parenting.

Research shows that programs that engage the whole family, whether teaching parenting skills in a clinic or modeling those skills in a home setting is effective in reducing aggression, disruptive and antisocial behavior, and preventing substance abuse later in life.[6] With SAMHSA grant funding, Centerstone has been able to implement these interventions in different communities in Tennessee, resulting in some incredible outcomes. However, sustainability often remains a barrier once grant-funding concludes.

Gaps between different care providing systems.
We hear a lot about America's fragmented health care system with current news focusing on mental health care. Children with serious emotional disturbances and mental disorders and their parents, in order to get the care they need, often have multiple providers and interface with

[5] American Academy of Child and Adolescent Psychiatry (AACAP). (2008) *Analysis of American Medical Association Physician Masterfile*. Washington, D.C.: American Academy of Child and Adolescent Psychiatry.
[6] National Research Council and Institute of Medicine. (2011) *IBID*

multiple agencies (i.e. department of children's services, juvenile justice, pediatric office, school, mental health center, etc.) The consequence is at best costly, and at worst dangerous. Care coordination models have proven effective outcomes. We encourage the expansion of these evidence-based models.

There is an opportunity here for greater collaboration and shared accountability by mandating mental health and substance abuse services be incorporated into the clinical models funded by the Affordable Care Act.

Transitions in Young Adult Care
Currently, when many adolescents with mental illness reach adulthood, they are at risk for experiencing a disruption in care if their state's Medicaid plan does not have an eligibility class or allowance for an "aging out" transition plan. Even though the ACA affords insurance coverage for dependents, up to the age of 26 years old, on their parent insurance plans, many youth will not have access to such coverage. This issue must be addressed as states consider plans for Medicaid expansion.

Exclusion of Community Mental Health Centers from HITECH Act
Thanks to the work of the Office of the National Coordinator for Health IT and the leadership of Sen. Sheldon Whitehouse, there have been tremendous advances towards creating standardized guidelines. However, since community mental health centers were left out of the 2009 HITECH Act, we have not been able to fully benefit from these advances. This one barrier sets up roadblocks for the achievement of several key goals for our field. If behavioral health were included in this Act, we would be positioned to:

- Effectively share information for purposes of coordination of care, including treatment plans, with primary providers, integrating our work to the benefit of the patient.
- Preventing overprescribing and other consequences of failed drug coordination such as drug-drug interaction and/or toxicity.
- Effectively track outcomes over time.

From the CMHC perspective, I do not know how centers can ensure that the care we are providing is what we would want for each of our family members without using Health IT tools. The first 25 years I spent in this field were with paper records, and I can tell you the difference between clinical supervision of paper records and clinical supervision using analytics tools is night and day. Thanks to the Ayers Foundation and the Joe C Davis Foundation, Centerstone was able to develop analytics tools similar to those used by for-profit businesses. With these tools, I can hotspot clinics, locations and centers where outcomes are lagging and rapidly develop localized quality improvement plans. I can ask questions, like "how many children are we serving in foster care and have been prescribed atypical antipsychotic medications in the last three months," or "how is our HEDIS client engagement metric last month compared to last year" and get the answer in one short minute.

As primarily Medicaid providers, most community mental health centers exist with very little financial margin, if any. Funding large health IT purchases is a luxury most cannot afford. Due to the contrary, due to the billions in cuts our field has experienced over the last four years, some

community mental health centers have been forced to simply shut their doors while many more have quietly ended programs and laid off large numbers of employees.

Inadequate Health IT capacity impedes the ability of the whole field to improve the quality of mental health care. Centers not using Health IT are, moreover, unable to use analytics tools to look at quality metrics or conduct rapid, targeted quality audits. Most health information exchanges do not include community mental health centers, and many states have no regulations allowing the sharing of information electronically with CMHCs. Systems and processes designed to foster provider communications and shared data through electronic means would greatly improve health care outcomes and reduce cost.

Strong bipartisan bills in both houses of Congress would correct this problem. HR 6043 championed by Representatives Tim Murphy of Pennsylvania and Marsha Blackburn of Tennessee and S. 539 introduced by Senators Whitehouse and Collins would authorize the participation of mental health and addiction providers in the healthcare revolution sparked by passage of the HITECH Act in 2009.

Need for Formal Mental Health Crisis Services in every Community
Not all states, counties, and community mental health centers offer formal crisis response services. Whether by telephone, internet, text or in-person, having a system of trained professionals for immediate response in the event of a crisis is, simply put, life-saving. I am in support of the President's recommendation to increase mental health first aid training. I believe that it makes sense for every teacher, law enforcement officer, and first responder in the U.S. to know how to detect issues and engage someone to get help. However, we need to make sure that as we are training people to seek help when in crisis, we have an existing network available to respond to the situation and provide evidence-based, outcomes-driven services. It is not enough to detect an issue; someone must be able to respond.

The Excellence in Mental Health Act, as part of its definition for what a community mental health center should do, requires that it provide crisis services. From my perspective, I know that this service not only saves life, it saves dollars, and I encourage this be considered vital to the service continuum of mental health safety net centers. In 2012, our Tennessee Crisis Call Center handled 18,350 emergency calls. Our Mobile Crisis therapists provided 6,081 face-to-face crisis assessments and in doing so prevented over 3,000 mental health-related hospitalizations – a huge cost savings for our state Medicaid program. Our Mobile Crisis team also aided in the appropriate hospitalization of another 3,000 individuals whose acute needs required a level of care beyond traditional outpatient services. Although this might not have saved Medicaid funds, it likely prevented countless tragedies.

Tennessee's TennCare Director and Deputy Commissioner for the state department of Finance and Administration, Darin Gordon as with our Commissioner of Mental Health and Substance Abuse Services, Douglas Varney should be recognized for their support of a formal, statewide Crisis Services program, serving the acute psychiatric needs of all Tennesseans.

Need for integrated care

The quality and length of life of our patients requires that we accurately assess and effectively treat their physical as well as their mental health needs. Mental health and physical health are as intricately intertwined as the brain is to the body. There is ample evidence that the current fragmented system with one part of the health care field treating mental illness and one treating physical illness is costly and, moreover, ineffective.

While community mental health services are an extremely small percentage when you look at state budgets, mental disorders are one of the five most costly conditions in the United States.[7] Fifty-two percent of Dual Eligible beneficiaries with disabilities have a psychiatric illness. Psychiatric illness is found in three of the top five most expensive diagnosis dyads.[8] In a study of the fee for service Medi-Cal system in California, when the 11 percent of the Medi-Cal enrollees with a serious mental illness (SMI) in the study were compared with all Medi-Cal enrollees, the SMI group's spending was 3.7 times higher than the total population ($14,365 per person per year compared with $3,914).[9] They also had a higher prevalence of other costly health disorders (diabetes, heart disease, chronic respiratory disease).

Nationally, one in eight visits to emergency departments is due to mental disorders, a substance use disorder, or both.[10] All of this healthcare, while costly, has not resulted in better outcomes. People with serious mental illnesses, on average, die 25 years earlier than people without such diagnoses, and this early mortality is primarily due to preventable physical health conditions.[11]

Community mental health centers are key to improving physical health while simultaneously lowering health care costs. The same skills we use to prevent mental health hospitalizations can be used to prevent physical health hospitalizations. The same skills our clinicians use to promote behavior changes in depressive cognitive thought patterns or patients with alcoholism can be used to help our patients quit smoking, exercise more, and make healthy food choices. The same nurses in our clinics that test for lithium and clozapine blood levels could test for hemoglobin A1C levels and draw lipid screens. The same case managers that do home visits and check on whether someone with schizophrenia is taking their medication and meeting their mental health goals also could teach the patient how to take their blood pressure and track their weight. Our expertise in behavior change is part of the solution to meet the triple aim of healthcare – reduced cost, improved health, and quality care. However, reimbursement for these activities varies depending on the Medicaid, Medicare and the managed care plan. Most CMHCs lack funds for training costs to train our staff, update our clinics, and obtain health IT systems that are compatible with primary care systems.

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[7] Agency for Healthcare Research and Quality (2013). *AHRQ Program Brief: Mental Health Research Findings*. Retrieved on January 19, 2013 from http://www.ahrq.gov/research/mentalhth.htm.

[8] Kronick RG, Bella M, Gilmer TP. (2009) *The faces of Medicaid III: Refining the portrait of people with multiple chronic conditions*. Center for Health Care Strategies, Inc.

[9] California 1115 Waiver Behavioral Health Technical Work Group. (2010). Beneficiary risk management: Prioritizing high risk SMI patients for case management/coordination. Presentation by JEN Associates, Cambridge, MA.

[10] Coffey R, et. al. (2010). Emergency Department Use for Mental and Substance Use Disorders. AHRQ.

[11] Parks J, Svendsen D, Singer P, Foti ME. (2006). *Morbidity and Mortality in People with Serious Mental Illness*. Alexandria, VA: National Association of State Mental Health Program Directors

Thankfully, in 2009, SAMHSA launched its Primary Care and Mental Health Care Integration (PBHCI) program. This program seeks to improve the physical health status of people with serious mental illnesses and reduce their total health care costs through integration of services. SAMHSA has funded 94 sites nationally, and, in cooperation with HRSA, has co-funded a national resource center helping community mental health centers like Centerstone and Federally Qualified Health Centers and other primary care practices to integrate physical and behavioral health care.

This funding stream has been very welcomed by Centerstone. Centerstone of Indiana was part of the second cohort to receive funds. My organization, Centerstone of Tennessee, was part of the 5th cohort. The biggest barrier to making integrated care sustainable for community mental health remains funding restrictions. Thankfully, we have seen more openness to lift those restrictions from managed care companies and states, and we are hopeful that this will be changing rapidly.

More direction from CMS (Centers for Medicaid and Medicare Services) to states regarding definition of what services can and should be provided by mental health organizations might be helpful to make sure those restrictions lift. The Primary Care Mental Health Care Integration program is most valuable if it is sustainable, and sustainability can be achieved by some common sense changes.

Need for Adequate and Consistent Coverage in ACA
Currently, there is no guidance issued ensuring that behavioral health has a seat at the table for Accountable Care Organizations (ACO) and other care coordination models being adopted across the U.S. It would be helpful, in the final Affordable Care Act (ACA) guidelines, for Congress to set forth instructions for the coverage of mental health and substance abuse services in the care and coverage models established by the ACA.

Conclusion
Recently, our country suffered a devastating loss of 28 precious lives – the 20 innocents, the 6 courageous teachers and administrators, the life of a mentally ill young man who did not get the care he needed, and the life of his mother, who did not get the help and information she needed. This tragedy, along with those in Colorado, Arizona, California, Virginia, and others has thrown a spotlight on our mental health system.

We have a long way to go to reach the President's vision of "making access to mental health care as easy as access to a gun." Our case managers, therapists, psychiatrists, nurses, researchers, and peer counselors are passionate about providing the best mental health care possible, and we seek to be part of the solution. However, we cannot achieve this solution in isolation. This is a moment that demands courage and action. Everyone in this room shares a responsibility for the future of mental health. Community mental health centers stand ready to work with you to improve the U.S. mental health system.

Thank you for your time and attention.