

**TESTIMONY OF LINDA ROSENBERG, MSW**

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NATIONAL COUNCIL FOR COMMUNITY BEHAVIORAL HEALTHCARE  
WASHINGTON, D.C.**

**ON BEHALF OF THE NATIONAL COUNCIL FOR COMMUNITY BEHAVIORAL HEALTHCARE**

**REGARDING:**

**FY 2010 APPROPRIATIONS FOR THE SUBSTANCE ABUSE AND MENTAL HEALTH  
SERVICES ADMINISTRATION**

- **CO-LOCATION OF PRIMARY CARE WITHIN MENTAL HEALTH ORGANIZATIONS**
  - **COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT**
  - **SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT**

**HEARING - LABOR, HEALTH, EDUCATION SUBCOMMITTEE  
MARCH 18, 2009 - 2:00 PM**

Good morning, Chairman Obey and members of the subcommittee. My name is Linda Rosenberg, and I am the President & CEO of the National Council for Community Behavioral Healthcare. The National Council represents 1,600 Community Mental Health Centers and other safety net community-based agencies. Collectively, they serve over 6 million low-income children and adults with mental health and addiction disorders nationwide.

### **High mortality rate among public mental health clients**

Mr. Chairman, Our nation's mental health and addiction treatment systems have been underfinanced for years. This situation is currently being exacerbated by reductions in state and local funding, at the same time that more Americans are losing their health insurance, alcohol sales are at an all time high, and more and more people are in need of treatment.

The public mental health system now confronts twin crises. First and foremost, the mortality rates among persons with serious mental illnesses in the United States can only be characterized as shocking. According to a December 2006 study of eight state mental health agencies conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA), persons with illnesses like schizophrenia and bipolar disorder **die – on average – 25 years sooner** than other Americans.<sup>1</sup> As best as we can determine, this constitutes the highest death rate among ANY population served by ANY agency of the U.S. Public Health Service that receive funding from this subcommittee.

These horrific mortality rates are primarily caused by co-occurring chronic diseases. Specifically, the people we serve in the public mental health system have an extraordinarily high incidence of asthma, diabetes, cancer, heart disease and cardio-pulmonary conditions of every shape and kind. Lack of access to primary care and specialty medicine is a critical factor in explaining these terrible clinical outcomes.

There is strong evidence of the positive health impact of access to high quality, integrated care for individuals with serious mental illnesses. A randomized trial conducted by Druss<sup>2</sup> in the VA system assigned individuals living with serious mental illnesses to receive primary care either through an integrated care initiative located in mental health clinics or to the VA general medicine clinic. A multidisciplinary team worked in the integrated care clinic where a nurse practitioner provided most of the medical care, a nurse care manager provided

patient education, liaison with behavioral health care providers, and case management services, and a family practitioner supervised the nurse practitioner and served as liaison to psychiatry and physicians in other medical services.

The model emphasized patient education, preventive services and collaboration with behavioral health providers. Individuals served in the integrated model were significantly more likely to have made a primary care visit, had a greater mean number of primary care visits, were more likely to have received 15 of 17 preventive measures, and had a significantly greater improvement in their health.

That is why, Chairman Obey, we owe a great debt to you. In the omnibus appropriations legislation that was just passed Congress last week, you fought for the inclusion of \$7 million in new SAMHSA funding to co-locate primary care capacity in Community Mental Health Centers. For the first time since the community-based mental health movement was created by President John Kennedy almost 50 years ago, CMHCs can develop the capacity to address a consumer's overall health. This integrated care model will enable us to do the little things.....like taking a patient's blood pressure, and the big things.....like arranging a cardiologist to see a consumer with schizophrenia who has heart disease.

Again, we appreciate your willingness both to listen – and take action – on behalf of people who cannot advocate for themselves.

### **State budget cuts undermine mental health care**

A parallel crisis we confront is the economic downturn, which is placing enormous pressure on state and local budgets. A recent study compiled by the National Association of State Mental Health Program Directors Research Institute, Inc. (NRI) found that most states' mental health agencies are experiencing budget cuts in the current and next fiscal years. Thirty-two of the 42 responding State Mental Health Agencies reported that their states are experiencing budget shortfalls in both the current fiscal year (FY2009) and next fiscal year (FY2010). Thirteen of the 42 states are already expecting budget shortfalls in FY2011.<sup>3</sup>

In response to these budget shortfalls, states are reducing services, including funding for individuals who are uninsured. They are also closing programs, reducing, or freezing provider reimbursement rates, and generally reducing access to critical treatment and support services.

For example, the State of Illinois is closing five of Chicago's 12 Community Mental Health Centers (CMHCs) – fully 40 percent of city's outpatient psychiatric capacity. In Iowa, the counties are running out of money and the state just announced a 6.5 percent across-the-board cut in services for low-income people with mental illnesses and developmental disabilities.

I should note here that these consumers do not magically disappear from our caseloads once public funding is cut. Withdrawing community-based supports for some of the most vulnerable people in American society typically results in a number of different outcomes – all of them awful: incarceration, homelessness, psychiatric emergency room visits, or placements in high cost state mental hospitals and nursing facilities.

At the very same time that our public funding is being reduced, CMHCs are reporting a surge of newly unemployed persons seeking mental health services. The National Council just completed a survey indicating a stunning 15 percent to 17 percent increase in initial psychiatric intakes. In fact, National Council members in Colorado served a record number of individuals and families in 2008 – over 90,000 men, women and children statewide. Substance abuse, anxiety, depression and the stress related to the economic downturn are contributing to requests for help. Emergency services for people who do not have healthcare benefits are also responsible for much of the increase in demand. Community providers also see a large number of National Guard members and reservists – particularly those located in rural areas – who have returned from Iraq and Afghanistan with PTSD, Traumatic Brain Injury, major clinical depression and anxiety. In short, my members are caught in a policy vise with declining state support on the one hand, and steadily increasing patient caseloads on the other.

### **Substance Abuse Continues to Ravage Our Communities**

According to the National Institute on Drug Abuse, addiction is defined as a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences. It is estimated that substance abuse represented 1 percent of the expenditures for all healthcare in 2003. As private insurance has come to play a smaller role in financing treatment for substance use disorders -- by 2003, less than 0.5 percent of private insurance spending was allocated to it – the share of public financing has increased -- by 2003, 77 percent of treatment for substance use disorders was publicly financed.

We cannot afford to continue to ignore the ravages of addiction. Untreated alcohol and drug addiction drains the U.S. economy of at least \$346 billion per year. Alcoholism alone is responsible for 500 million lost work days each year.

Addiction affects one in ten Americans and one in four children. In 2007, of the 23.2 million Americans with alcohol or drug problems in 2007, only 2.4 million—roughly one in ten—received treatment at a specialty treatment facility, leaving 20.8 million untreated.

We know that prevention and early intervention strategies are critical but we fail to invest adequate resources into their development and implementation. Addiction typically begins in adolescence; research shows that the earlier a person begins to use drugs the more likely they are to progress to more serious abuse and addiction. And we know that treatment works. Over two thirds of the people with addiction do achieve recovery and treatment increases the likelihood of transitioning from use to recovery. Unfortunately, the current treatment system is insufficient and needs significant investment.

State and local governments fund half of the substance abuse treatment provided in this country – and the current economic downturn is resulting in reductions in substance abuse prevention and treatment spending across the nation. For example, of 41 states and territories responding to an inquiry by the National Association of State Alcohol/Drug Abuse Directors (NASADAD), 51.2 percent have seen a reduction in services in the past year. In states such as New York, state agencies are being forced to choose between life-saving services. With state budget cuts, the New York State Office of Alcoholism and Drug Abuse Services is being "forced to choose between the AIDS programs and its core substance abuse services".<sup>4</sup> As another example, Utah state legislators are calling for a 15 percent cut across all state agencies; resulting in about \$45 million in cuts to the Utah Department of Human Services – of which about \$30 million in cuts would be directed towards substance abuse and mental health programs in the state.<sup>5</sup>

One additional program that SAMHSA supports to improve the efficiency of the publicly-funded addiction treatment system that the National Council urges increased investment in is the Strengthening Treatment Access and Retention (STAR-SI). Through a partnership with the NIATx Resource Center at the University of Wisconsin–Madison, STAR-SI has demonstrated that process improvements can help systems reduce waste and increase efficiencies. Using NIATx principles, STAR-SI grantees are making changes that streamline processes, eliminate duplication of effort, and reduce costs across an entire payer-provider system. With regards to admissions alone, the benefit-cost-ratio for STAR-SI is 2.2, in present dollars, over the course of the grant. One STAR-SI provider stated that “[STAR-SI] is one of the best programs I’ve seen after several years of being in the field. I hope it continues to grow and do well.”

Therefore, while the Recovery Act is very helpful to us – particularly the Medicaid policy changes -- we are turning to this subcommittee for additional federal support. Specifically, we have two priorities:

- A \$35 million increase for the integrated mental health/primary care program. As you well know, these funds help us to save lives. Furthermore, the funding increment we are seeking is consistent with the second year of funding for the Children’s Mental Health Services Program, another initiative you started in FY 1996.
- A \$100 million increase for the SAMHSA’s Community Mental Health Services Block. I should note that the block grant has not received an appropriations increase in almost a decade, and has lost more than 50% of its purchasing capacity over the same time period. These additional funds would flow directly to CMHCs in states hit hard with budget deficits and high unemployment.
- A \$150 million increase to the Substance Abuse Prevention and Treatment Block Grant. This increase will go a long way in ensuring that our nation’s prevention and treatment system can respond to the increasing demand.

We know that you are confronted with difficult choices in the FY 2010 appropriations cycle. But, Mr. Chairman, we can assure you that these new dollars would be employed to assist persons in psychiatric crisis and provide primary care to people in desperate need.

Thanks for the opportunity to testify today, and I am happy to answer any questions you may have.

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<sup>1</sup> Mauer, B. Morbidity and Mortality in People with Serious Mental Illness. National Association of State Mental Health Program Directors Medical Directors Council. October 2006.

<sup>2</sup> Druss, B et al. Integrated medical care for patients with serious psychiatric illness. Archives of General Psychiatry, Vol 58, September 2001.

<sup>3</sup> Roberts, K. & Lutterman, T. SMHA budget shortfalls: FY 2009, 2010, & 2011. National Association of State Mental Health Program Directors Research Institute, Inc. December 2008.

<sup>4</sup> Trapasso, C. Program to help addictions in danger. New York Daily News. February 24, 2009. Available via: [http://www.nydailynews.com/ny\\_local/queens/2009/02/24/2009-02-24\\_program\\_to\\_help\\_addicts\\_in\\_danger.html](http://www.nydailynews.com/ny_local/queens/2009/02/24/2009-02-24_program_to_help_addicts_in_danger.html)

<sup>5</sup> Stryker, A. State budget cuts could cripple county substance abuse efforts. Daily Herald. January 14, 2009. Available via: <http://www.heraldextra.com/content/view/295821/17/>