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INTRODUCTORY REMARKS OF
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DEPUTY COMMISSIONER KEVIN MARTONE'S INTRODUCTORY REMARKS:
IMPACT OF THE STATES' ECONOMIC CRISIS ON
AMERICA'S PUBLIC MENTAL HEALTH SYSTEM
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On behalf of the National Association of State Mental Health Program Directors (NASMHPD), I want to welcome you to this congressional staff briefing addressing the impact of the current state fiscal crisis on America's public mental health safety net. NASMHPD represents the public mental health authorities in all 50 states, 4 territories and the District of Columbia. Together, these agencies administer mental health systems that serve over 6 million low income children and adults with mental illnesses every year.

My name is Kevin Martone and I am a Deputy Commissioner of Human Services in the State of New Jersey and I lead the Division of Mental Health and Addiction Services. Our agency serves over 330,000 children and adults with serious mental health and addiction disorders. Prior to my role as a state official, I served as the CEO for a supportive housing provider, Vice President for the Supportive Housing Association of New Jersey, and in other clinical and administrative positions in community mental health. Before going any further, let me take a moment to thank Sen. Debbie Stabenow for sponsoring this congressional staff briefing. With the retirement of Sen. Pete Domenici (R-NM) and the death of Sen. Ted Kennedy (D-MA), Sen. Stabenow's leadership in bipartisan efforts to improve mental health care in America is more important than ever.

Let me also take this opportunity to thank the Mental Health Liaison Group (MHLG) for supporting today's briefing. In particular, I want to acknowledge the President of the MHLG Steering Committee and staff member of the National Association of Social Workers, Jim Finley, who is in the audience today.

I will be spending the next few minutes walking you through a very brief slide presentation that details the enormous impact that the state fiscal crisis is now having on access to public mental health services. These data come from an annual state survey administered by the NASMHPD Research Institute (NRI). Further, it is very important to note that these financial estimates are likely to be conservative because the data is based on responses from 45 of the 50 states.

SLIDE # 1

What the first slide shows is that states have been forced to cut mental health agency budgets by a combined total of nearly $2.2 billion over the last three fiscal years. This appears to be the largest single combined reduction to mental health spending in the United States in generations – certainly since the start of the deinstitutionalization movement in the late 1960s. Some states have been forced to make cuts equaling 20% of their total mental health spending. In the worst hit states, reductions approaching 40% are being contemplated.

As state legislatures convene and address extreme budget shortfalls, all the information

we have indicates that the overall total of mental health funding reductions will actually increase – perhaps substantially – by June 30, 2011, and then again going into FY 2012. In many states, FY 2011 revenues receipts are continuing to come in lower than expected, meaning that many states will require additional FY 2011 cuts between now and the end of the fiscal year for states to balance their budgets. Projections for overall state budget shortfalls in FY 2012 are now as high as $125 billion, meaning that the FY 2012 budgets that state legislatures will approve this spring will bring an additional round of cuts on top of reductions already made in FY 2011 and the previous two years.

SLIDE #2

For example, you can see in this slide many states have been forced to reduce funding for a wide array of community-based interventions including crisis services, targeted case management, prescription medications and outpatient clinics. These services are at the heart of every public mental health system in the country. As state mental health authorities, we finance these community-based supports as a means of keeping people with mental illnesses out of more expensive psychiatric hospitals, emergency rooms, nursing facilities and jails. In fact, these services enable people to be contributing members in our communities. The evidence is clear that preventative, community-based services are cost efficient and produce positive outcomes for most people with mental illness. As Pamela Hyde, the SAMHSA Administrator recently stated in *Business Week*, "The value of behavioral health services is well documented. Studies have shown that every dollar invested in evidence-based treatments yields $2 to $10 in savings in health costs, criminal and juvenile justice costs, educational costs and lost productivity."

SLIDE # 3

In the face of the fiscal crisis, state mental health authorities have sought to maintain access to essential services while reducing capacity. You see that demonstrated in this slide, which shows that – nationwide – we've been forced to close nearly 4,000 public psychiatric hospital beds. The impact of these lost beds was illustrated in a recent *New York Times* article. The story quoted Stacey Puckett, executive director of the Oklahoma Association of Police Chiefs, as saying that her officers were taking consumers in psychiatric crisis on drives of "6, 8, 10 hours" across the state. "It's the bed shortage," she explained. "We don't have enough beds for the numbers…" in the wake of a $17 million reduction to Oklahoma's mental health budget.

SLIDE # 4

This next slide illustrates the challenges we confront as state mental health administrators. In the face of the fiscal crisis, we are struggling to maintain our Medicaid financed care since these services support children and adults with the most severe mental illnesses. The result is that we are forced to withdraw state and county general revenues from a wide array of programming.

The hardest hit programs are indigent care initiatives providing mental health services to low income people and uninsured adults – many of whom lost health insurance coverage in the recession. These consumers are typically low income individuals who are still ineligible for Medicaid. Let me take a moment to give you some specific examples of what reductions to indigent care mean on the ground:

- In Iowa, the state mental health authority might be forced to eliminate 129 psychiatric hospital beds at the state's four state-run mental health facilities.

- In Mississippi last year, the total state mental health agency funding reduction totaled more than $17 million resulting in the loss of mental health care to more than 2,800 low income individuals.
- In the State of Washington, a full psychiatric ward at Western State Hospital is closing and Community Mental Health Centers are scheduled to sustain an $18 million across-the-board funding cut.

SLIDE # 5

But--as you can see in the final slide--these budget cuts come at a time when the vast majority of states are reporting a significant increase in demand for services from the public mental health safety net. Fifty-six percent (56%) of states are reporting increased demand for community-based mental health care. Fully 29% of our member agencies are reporting significant utilization increases for crisis psychiatric services. In a related question, 18% of state mental health agencies responding to our survey report increased emergency room use.

In looking ahead, one of the health policy questions we ask ourselves at NASMHPD is: how are we going to serve an even larger number of consumers with much less capacity? Specifically, with the implementation of health care reform, some private studies indicate that an additional 2.5 million low income persons with serious mental disorders will be served by the public mental health system in 2014. That equals a nationwide increase of nearly 30% in the number of consumers receiving behavioral health care from state mental health agencies. If we are forced to continue reducing intensive community-based services and closing psychiatric hospital beds, we will not have the necessary infrastructure, services and workforce to meet existing demands, let alone a growing demand for these very services expected with the Affordable Care Act (ACA).

Each of my fellow panelists here today…..Sheilah Clay from the Neighborhood Service Organization; Detroit Police Commander Shereece Fleming-Freeman; Craig Knoll, Executive Director, Threshold Services in Silver Spring, MD; Susan Reed, a consumer of mental health care; and Lt. Col. James Walsh, President of NAMI Alabama and the family member of a person with mental illnesses will be providing important information on how state mental health agency spending cuts have hurt front line providers, increased the burden on local law enforcement agencies, and reduced mental health care for consumers, children and families. Further, I believe that we are all united in our basic message: in short, we need help to serve an increasing number of some of our most vulnerable citizens. We need that federal assistance to come in two forms:

- First, the National Association of State Mental Health Program Directors strongly recommends increasing the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Mental Health Block Grant. The Block Grant is the only federal program available to help public mental health agencies recover state and county service dollars lost during the current fiscal crisis. We believe in this time of fiscal austerity that the President's proposed budget recognizes the importance of preserving the public mental health safety net and we strongly support at least the $14 million increase he recommends. Now is not the time to cut any appropriations at SAMHSA, particularly as you grapple with the current FY 2011 budget. In the fiscal crisis we now confront, SAMHSA funding across programs for

homeless Americans with psychiatric illnesses, returning veterans with post-traumatic stress disorder (PTSD) and children with serious mental and emotional disturbances is even more important.

- Second, we need policy and decision makers to fully include behavioral health into all healthcare conversations. Improving and strengthening Medicaid as a cornerstone in healthcare reform must be a central goal. Recognizing behavioral health as an integral part of healthcare reform will not only improve people's lives, but will bend the cost curve and add to our economy. An individual's brain is not detached from his or her body; similarly, behavioral health should not be detached from overall healthcare.

Thank you for attending our briefing this morning. We'll be taking questions at the end of the panel discussion. Please help me welcome Sheilah Clay, CEO of the Neighborhood Service Organization in Detroit, Michigan.