EXAMINING SAMHSA'S ROLE IN DELIVERING SERVICES TO THE SEVERELY MENTALLY ILL

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BEFORE THE

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OF THE

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HOUSE OF REPRESENTATIVES

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SUBMITTED MATERIAL

EXAMINING SAMHSA'S ROLE IN DELIVERING SERVICES TO THE SEVERELY MENTALLY ILL

WEDNESDAY, MAY 22, 2013

House of Representatives,
Subcommittee on Oversight and Investigations,
Committee on Energy and Commerce,
Washington, DC.

The subcommittee met, pursuant to call, at 10:05 a.m., in room 2123 of the Rayburn House Office Building, Hon. Tim Murphy (chairman of the subcommittee) presiding.

Members present: Representatives Murphy, Burgess, Blackburn, Gingrey, Scalise, Harper, Olson, Gardner, Griffith, Johnson, Long, Ellmers, Upton (ex officio), DeGette, Braley, Butterfield, Castor, Tonko, Green, and Waxman (ex officio).

Also present: Representative Cassidy.

Staff present: Karen Christian, Chief Counsel, Oversight; Brad Grantz, Policy Coordinator, O&I; Brittany Havens, Legislative Clerk; Robert Horne, Professional Staff Member, Health; Alan Slobodin, Deputy Chief Counsel, Oversight; Sam Spector, Counsel, Oversight; Jean Woodrow, Director, Information Technology; Stacia Cardille, Democratic Deputy Chief Counsel; Anne Morris Reid, Democratic Professional Staff; Brian Cohen, Democratic Staff Director for Oversight and Investigations Subcommittee and Senior Policy Advisor; Stephen Salsbury, Democratic Special Assistant; and Elizabeth Letter, Democratic Assistant Press Secretary.

OPENING STATEMENT OF HON. TIM MURPHY, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. Murphy. Good morning, everyone. I now convene this morning's hearing entitled "Examining SAMHSA's Role in Delivering Services to the Severely Mentally Ill."

Since I became the Chairman of the Subcommittee on Oversight and Investigations, shortly after the December 14, 2012, elementary school shootings in Newtown of last year, we began looking into the federal programs and the resources devoted to mental health and mental illness. We did so to ensure federal dollars devoted to mental health are reaching those individuals with serious mental illness and helping them obtain the most effective care.

One lesson we must immediately draw from the Newtown tragedy is that we need to make it our priority to get those with serious mental illness who are not presently being treated into sound, evidence-based treatments.

In 2009, the Substance Abuse and Mental Health Services Administration, otherwise known as SAMHSA, estimates that about 11 million U.S. adults had serious mental illness, and 40 percent of these individuals did not receive treatment. While the vast majority of individuals with a mental health condition are nonviolent, director of the National Institute for Mental Health, Dr. Thomas Insel, told this subcommittee at our March 5 public forum that effective treatments, which include medication adherence and evidence-based psychosocial psychotherapy, can reduce the risk of violent behavior 15-fold in persons with serious mental illness.

Getting these individuals into treatment is a crucial first task, and SAMHSA, as the federal agency whose mission includes reducing the impact of mental illness on America's communities, should be playing a central role in this effort. But based on our work to date, SAMHSA has not made the treatment of the seriously mentally ill a priority. In fact, I am afraid serious mental illness such as schizophrenia and bipolar disorder may not be a concern at all.

Consider the 2011–2014 SAMHSA strategic plan entitled "Leading Change." SAMHSA continues to think in broad terms such as "behavioral" and "emotional" health, promoting such concepts as "wellness" or "recovery." Not once in this entire 117-page document will you find the words schizophrenia or bipolar disorder. Nowhere in the written testimony that was provided to this committee yesterday by the SAMHSA administrator do those words appear. And nowhere on SAMHSA's Web site or in their publications can you learn about the increased risk of violent behavior by persons with untreated mental illness. It is as if SAMHSA doesn't believe serious mental illness exists.

If we have learned one thing from the horrible acts committed by Seung-Hui Cho at Virginia Tech in 2007; Jared Loughner in Tucson; James Holmes at the Aurora, Colorado, theater in July 2012; or Adam Lanza, it is this: that individuals with untreated severe mental illness are a significant target for self-directed violence, including suicide or violence against others. In at least 38 of the last 62 mass killings, the perpetrator displayed signs of possible mental health problems. In so many of these instances, parents desperately tried to get their mentally ill loved one to help before the act. Sadly, they failed, oftentimes because the current system of care for those with serious mental illness is broken.

Examining what SAMHSA is doing to grapple with this heartbreaking truth is the main reason we are gathered here this morning. The Center for Mental Health Services, housed at SAMHSA, has a budget of approximately $1 billion per year. It awards most of these funds through a combination of competitive and formula grants. I am concerned because the Committee has seen substantial evidence that too many of these grants are directed to advancing services rooted in unproven social theory and feel-good fads rather than science. If SAMHSA were to use an evidence-based approach to identifying how to prioritize its resources—like other federal agencies do—would their record, not to mention their strategic initiatives going forward, look the same as they do now?

For example, in 2012, an annual conference that has been funded by SAMHSA for many years at which the SAMHSA administrator herself regularly delivers a keynote, a conference known as Alternatives, an hour-and-a-half workshop was held, described as follows: “Unleash the Beast is a mind/body fitness program that looks to the animals of the jungle for wisdom and skills that can benefit our lives in a myriad of ways. Through animal-inspired movements, behaviors, and expressions, participants are encouraged to shed layers of formal conditioning in order to return to their primal nature.”

While mental and physical health is important, I question the value of this exercise in advancing the treatment for mental illness in humans let alone seriously mentally ill, and I question if there is any scientific merit at all.

I would also ask why SAMHSA provides grant funding year after year in the millions of dollars in aggregate to organizations that are outwardly hostile to the sciences of psychiatry and psychology. These groups openly deny that mental illness exists, claiming there is nothing out of the ordinary when an individual hears voices or experiences extreme mental states, and that these should be celebrated as nature’s gift to mankind, contributing to artistic creativity and human diversity.

Leaders of these organizations—including at least one of which SAMHSA has elevated to the status of a “National Technical Assistance Center” and received at least $300,000 in taxpayer dollars the past year—have actively encouraged supporters to “occupy” the 2012 annual convention of the American Psychiatric Association, decrying the professional association’s role in developing the Diagnostic and Statistical Manual of Mental Disorders, otherwise known as the DSM. “Psychiatric labeling,” as they say, is “a pseudoscientific practice of limited value in helping people recover.”

When SAMHSA-funded organizations are not busy encouraging those with mental illness to go off their prescribed medications—and, yes, they do that—or destroying trust between individuals with serious mental illness, their family caregivers, and their physicians, these taxpayer-backed groups are actively lobbying against effective evidence-based treatment like Assisted Outpatient Treatment—otherwise known as AOT—laws, a less-restrictive alternative to involuntary commitment is what AOT is. Numerous academic studies have shown AOT to be incredibly effective in reducing re-hospitalizations and re-arrests among, until-then, untreated individuals with serious mental illness.

As an agency of the U.S. Public Health Service, we expect SAMHSA’s work to be firmly rooted in evidence-based practices in deed and not just by word, enduring high-level scientific peer review at the hands of licensed mental health professionals. Perhaps some of it is and I know some of it is, but much of it appears to fall far short of such standards.

To get answers to our questions, this morning, we will hear from Pamela Hyde, the Administrator of SAMHSA since 2009, on our first panel. On our second panel, we will hear from E. Fuller Torrey, a psychiatrist and long-time observer of SAMHSA; Dr. Sally Satel, a member of the National Advisory Council to SAMHSA’s Center for Mental Health Services for 4 years; and Joe Bruce, a family man from Caratunk, Maine, whose life was irrevocably changed by one SAMHSA program in particular.

Joe's wife, Amy, was murdered by their son, Will, only months after being released from a psychiatric hospital where he had been treated for schizophrenia. Reflecting on this horrific act several years ago, Will noted that, un-medicated at the time, he believed he was a clandestine operative under orders to kill his mother, an Al Qaeda operative. Joe believes the efforts of a SAMHSA-funded organization obtained his son's premature release from the hospital without putting in place a mechanism for ensuring that Will would remain on his medication. Joe, we extend our condolences to you and your family, and thank you for sharing your moving story with us today.

We will also hear from Dr. Joseph Parks, III, Chief Clinical Officer of the Missouri Department of Mental Health, who has substantial experience working with SAMHSA grant funded-projects. And I want to thank all of our witnesses for being here today.

[The prepared statement of Mr. Murphy follows:]

PREPARED STATEMENT OF HON. TIM MURPHY

Since I became the Chairman of the Subcommittee on Oversight and Investigations, shortly after the December 14, 2012, elementary school shootings in Newtown, we began looking into the federal programs and resources devoted to mental health and mental illness. We did so to ensure federal dollars devoted to mental health are reaching those individuals with serious mental illness and helping them obtain the most effective care.

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Getting these individuals into treatment is a crucial first task and SAMHSA, as the federal agency whose mission includes reducing the impact of mental illness on America's communities, should be playing a central role in this effort. But based on our work to date, SAMHSA has not made the treatment of the seriously mentally ill a priority. In fact, I'm afraid serious mental illness such as schizophrenia and bipolar disorder may not be a concern at all to SAMHSA.

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If SAMHSA were to use an evidence-based approach to identifying how to prioritize its resources—like other federal agencies do—would their record, not to mention their strategic initiatives going forward, look the same as they do now?

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While mental and physical health is important, I question the value of this exercise in advancing the treatment for mental illness in humans. And, I question if there is any scientific merit.

I would also ask why SAMHSA provides grant funding, year after year—in the millions of dollars in aggregate—to organizations that are outwardly hostile to the sciences of psychiatry and psychology. These groups deny that mental illness exists, claiming there is nothing out-of-the-ordinary when an individual hears voices or experiences extreme mental states—and that these should be celebrated as nature's gifts to mankind, contributing to artistic creativity and human diversity.

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We will also hear from Dr. Joseph Parks III, Chief Clinical Officer of the Missouri Department of Mental Health, who has substantial experience working with SAMHSA grant funded-projects. Thank you to all our witnesses today.

# # #

Mr. MURPHY. I would now like to give the ranking member an opportunity to give remarks of her own.

OPENING STATEMENT OF HON. DIANA DEGETTE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO

Ms. DEGETTE. Thank you very much, Mr. Chairman. Your passion about this issue is evident. We appreciate everything that you are doing to have these hearings on mental illness and gun violence. I want to join you in welcoming all of our witnesses here today and looking forward to hearing your perspectives on SAMHSA.

As we all know, Congress has directed SAMHSA to provide services to prevent, treat, and recover from mental health and substance abuse disorders. The Agency administers a number of funding streams, including competitive, formula, and block grant programs. It also collects data on mental illness, behavioral health, and substance abuse. Chairman Murphy and I have been working together to identify areas where, on a bipartisan basis, we can agree to commonsense solutions.

And in his opening statement, the chairman has identified a number of important issues regarding SAMHSA that we need to work together to address. Some of those criticisms I think really do merit this committee's consideration. Other criticisms that we see out in the world only distract us from our real purpose, which is to ensure that we identify people who are living with mental illness before crisis situations arrive and make sure that they can get the mental health treatment that they so desperately need.

For example, we will hear that SAMHSA is too focused—actually, we did hear in the chairman's opening statement that SAMHSA is too focused on substance abuse programs, not dedicated to addressing serious mental illness. And in fact, mental health programs account for 27 percent of SAMHSA's overall budget in fiscal year 2013 and substance abuse comprises 68 percent of its budget. And so if this is really a legitimate problem that is leading towards a lack of addressing serious mental health issues, then it is Congress' responsibility to fix that.

Every year, Congress determines through the appropriations process what SAMHSA spends on mental health versus substance abuse. And so if Congress wants SAMHSA to focus more on mental health, we should work together to provide the Agency with more resources to do so. And I look forward to working with the chairman and the rest of the members of this committee to make that happen as the appropriations process develops this spring.

I also would be happy to work with the chairman and everyone on this committee to ensure that the Agency has the resources it needs to do the job and that we enact legislation that guarantees that we actually fund the programs that we think are important.

Another criticism that we have heard and I agree with it is that we don't have enough data to know what programs SAMHSA funds are working well with and what are not, but you will not find a bigger advocate in Congress for science-based research than me. I have been fighting for it in every area for decades: abstinence-only sex education, stem cell research, on and on and on. And if we want these programs to work, they have to be science-based.

And so what we need to do is make sure that SAMHSA, States, and other grantees have clear reporting requirements and metrics so that in fact we can measure what worked and what doesn't work and that we can measure progress.

And so I am hoping, Mr. Chairman, that we can work together on this, too, improving SAMHSA reporting requirements and figuring out on an evidence-based basis what really works.

Now, I just want to raise one concern about these hearings. This is the third proceeding on mental health, and for the third time we don't have a witness appearing to provide the perspective of people who are living with mental illness. We discussed this the other day. We keep talking about issues that affect their daily lives. We keep having providers and family members and others coming in to talk about people with mental illness but we haven't had people who have mental illness directly talk to us, and I think there are people who would be willing to come forward and talk about their concerns and their issues, which of these SAMHSA programs work for them, which of them don't work for them. What about the privacy provisions and what about the everything, the funding and everything? So I am hoping in our next hearing we could have a panel of people who have mental illness to talk about from their perspective what works and doesn't work.

Finally, as we discuss ways in which SAMHSA invests in the prevention and treatment of mental illness in this country, I think that it is important that we do not lose sight of the key role recently enacted legislation plays in advancing our shared goal of improving access to mental health services for the millions of Americans experiencing mental illness.

The Mental Health Parity Act—which Chairman Murphy and I both cosponsored along with a number of other members of this committee—ensures that group health plans and ensures offering mental health and substance use disorder benefits do so in a manner that is comparable to coverage for general medical and surgical care. The Affordable Care Act, building on this parity legislation, will expand mental health and substance use disorder benefits and parity protections for 62 million Americans. The implementation of the Affordable Care Act and continued support of SAMHSA programs that work will go a long way in ensuring that people with serious mental illness have access to the treatments they need.

I yield back, Mr. Chairman. Thank you for your comity.

Mr. MURPHY. I thank the gentlelady for her comments.

Now turning to the chairman of the full committee for 5 minutes, Mr. Upton.

OPENING STATEMENT OF HON. FRED UPTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. UPTON. Well, thank you, Mr. Chairman.

Today, we are here to examine the role of the Substance Abuse and Mental Health Services Administration (SAMHSA) in delivering services to the severely mentally ill, and I certainly appreciate the chairman's interest, passion, and professional insight regarding this issue.

In the wake of the tragic shootings at Sandy Hook, this subcommittee has stepped up to examine an important question: what is the federal government doing to address serious mental illness? And I commend the chairman for leading this investigation.

While the vast majority of individuals with a mental health condition are nonviolent, in March, the Subcommittee learned from Dr. Tom Insel, Director of the NIH, National Institute of Mental Health, the important fact that treatment can reduce the risk of violent behavior 15-fold in persons with serious mental illness. This morning, we direct our attention to the primary federal agency responsible for supporting community-based treatment services for mental illnesses.

With an annual budget of nearly $1 billion, SAMHSA's Center for Mental Health Services could serve as a key part of the Federal Government's efforts to address the tragic impacts on our society of such serious mental illnesses as major depression, schizophrenia, and bipolar disorder. This includes connecting these individuals with effective treatments at a time when 40 percent of adults with serious mental illness report not receiving any treatment at all. Not doing so increases the chances that the next James Holmes or the next Adam Lanza will in fact fall through the cracks.

Unfortunately, I am concerned that SAMHSA may not be directing those dollars to treat those with the most severe of mental illnesses. Further, I am also concerned about the commitment to science and the scientific process—including psychiatry—displayed by several major grant recipients. We need to be investing our dollars in the programs with the best record for treating those who have mental illnesses.

[The prepared statement of Mr. Upton follows:]

PREPARED STATEMENT OF HON. FRED UPTON

Today we are here to examine the role of the Substance Abuse and Mental Health Services Administration (SAMHSA) in delivering services to the severely mentally ill. In the wake of the tragic shootings at Sandy Hook Elementary School in Newtown, Connecticut, this subcommittee has stepped up to examine an important question: what is the federal government doing to address serious mental illness. I commend Chairman Murphy for leading this investigation.

While the vast majority of individuals with a mental health condition are nonviolent, in March, the subcommittee learned from Dr. Tom Insel, Director of the National Institute of Mental Health, the important fact that treatment can reduce the risk of violent behavior fifteen-fold in persons with serious mental illness. This morning, we direct our attention to the primary federal agency responsible for supporting community-based treatment services for mental illness.

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Unfortunately, I am concerned that SAMHSA may not be directing those dollars to treat those with the most severe of mental illnesses. Further, I am also concerned about the commitment to science and the scientific process—including psychiatry—displayed by several major grant recipients. We need to be investing our dollars in the programs with the best record for treating those who have mental illnesses.

As the experts joining us today, including Doctors Torrey and Satel will share with us, SAMHSA's programs do very little for those at the extreme end of the spectrum of mental illness, who lack awareness of their own condition, who deny that they have a disorder demanding treatment, and who see no reason to follow a medication regimen. I want to especially thank our witness, Joe Bruce, for joining us today to share his family's tragic story.

I also welcome Administrator Hyde and look forward to hearing about her agency's plans to address these concerns about the most vulnerable among our nation's mentally ill.

# # #

Mr. UPTON. And at this point I will yield the balance of my time to Dr. Burgess.

Mr. BURGESS. I thank the chairman for yielding.

You know, the recent notorious tragedies have brought to light the challenges that are faced by those suffering from mental illness today in the United States. Certainly SAMHSA has an important role as the point agency to address mental health issues, but out of their budgets there are questions that have come up about the lack of oversight and accountability. Is it in the public's interest to use limited SAMHSA funding to encourage alternate approaches to treating mental illness? Is it the best use of their funding to support an organization that lobbies against programs that encourage proven treatment methods such as psychiatric medication adherence?

And now, we are going to hear from witnesses in the second panel who raised serious questions about the use of the funding to commission oil paintings and providing for an annual staff musical within the agency. This agency is responsible to use its resources to ensure that the almost 10 million Americans with mental illness can be productive members of society. It is our job on the committee to assess both the successes and the shortfalls of the Agency to determine where the Agency's resources can be used most effectively and ensure they are doing their best job.

I look forward to hearing about that today and I will yield the balance of the time to Dr. Gingrey.

Mr. GINGREY. I want to thank you again, Mr. Chairman, for your leadership on this important issue. I want to thank Dr. Burgess as well and highlight one particular perspective that is often overlooked: adherence to a planned treatment. All too often, individuals suffering from mental illness, substance abuse disorders, or both are under the treatment of a qualified medical professional. They have been prescribed an appropriate regimen of medicine, yet they struggle to take their medication consistently. This results in relapses and, of course, disease progression. As you know, relapses result in significant suffering, increased cost to the patient and the healthcare system, and in some cases, violent, criminal behavior.

Mr. Chairman, as we seek today to highlight the most efficient use of federal resources for this particular vulnerable population, I believe that improving adherence, whether by novel drugs or innovated management of the disease, is particularly important and I look forward to working with the Subcommittee to pursue policies particularly at SAMHSA to ensure the best possible treatment options available to providers and patients confronting mental illness and substance abuse in order to improve health and health economic outcomes.

Mr. Chairman, thank you for your patience and I yield back.

Mr. MURPHY. The gentleman yields back. I now recognize for 5 minutes Mr. Butterfield.

OPENING STATEMENT OF HON. G.K. BUTTERFIELD, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NORTH CAROLINA

Mr. BUTTERFIELD. Let me thank you, Mr. Chairman, for yielding time. I thank the ranking member, Ms. DeGette, for her comments and I want to associate myself with each word that she uttered a few minutes ago. She is exactly correct.

I thank the chairman of our full committee, Mr. Upton, and all of you who have a profound interest in the subject.

This is a very, very important subject not just in my congressional district but throughout the country. Let me say good morning to the witnesses and thank you so very much for coming today to be a part of this process.

Funding from the Substance Abuse and Mental Health Services Administration—and we call it SAMHSA—has helped my State enormously. It has helped probably every State in the country but I can speak specifically to my State. For fiscal year 2012 my State of North Carolina received $20 million from Mental Health Services. And if my colleagues will check, you will see that there has been significant federal investment with this population all across the country. It is a good program. It is a valuable program.

In my congressional district, the Durham County Health Department, for example, received funds to enhance services and support available to 16- to 21-year-olds with serious mental health issues and their families. Also, the Child and Parent Support Services, Incorporated, in Durham received funds to assist clinicians working with child welfare and even military families.

But we continue to see cost-cutting measures like sequestration and the Ryan budget which endanger important programs like those in Durham and throughout my State and throughout the country. There is an article this morning in the Hill Newspaper that even warns of round two of sequestration. So many of our citizens think that sequestration was a 1-year proposition, but it is a 9-year proposition and now we are getting ready for round two. And Mr. Chairman, we have done absolutely nothing to fix sequestration. I support full repeal of sequestration.

Mr. Chairman, the 2013 spending plan that SAMHSA released earlier this month shows that the sequester will result in cuts of over $200 million in SAMHSA funding this year, a cut of almost 6 percent, and next year, it would certainly be more. Every single SAMHSA program will be affected. Our citizens need to know that.

Every SAMHSA program will be affected. The Mental Health Block Grant Program is being cut by $23 million. Children's mental health services are cut by $6 million. Suicide prevention funds will be cut; programs to help the mentally ill people who are homeless will be cut. This will mean fewer SAMHSA grants and fewer people with access to mental health services.

Mr. Chairman, we must continue to support those struggling with mental illness and their families by continuing to strengthen these very important programs.

At this time, I will yield the balance of my time to the gentlelady from Florida.

Ms. CASTOR. Well, I thank my colleague for yielding and I thank the chairman and the ranking member for calling this very important hearing.

It is vital that this committee provide oversight of the mental health services provided by the Federal Government in partnership with state and locals and for families. What I hear consistently from families and mental health professionals at home is simply that the needs so far outstrip the resources that are available to families and professionals today. That point was made by Ranking Member DeGette, and she is right.

For example, just yesterday, I had about 10 emergency room physicians, fairly new doctors, pay a visit up here on Capitol Hill and our conversation got to the point of what they do every day when they are confronted with some of our neighbors who have mental health issues, and they made a point again, there simply aren't enough places for people to receive counseling and treatment. They said just what we know, one of the real problems is the laws say unless someone is a danger to themselves or to others, they are going to be discharged. And that is simply not going to help us address the needs of our families.

This is similar to what I hear from school districts, teachers, and families and schools. They know when young children have issues and there are great counselors out there but significantly not enough to provide the basic treatment and counseling that they need to make sure that they are healthy and can succeed in school. So we need to focus on what works in our community. I hope we will be able to address that today.

The answers are different for the Tampa Bay area than they are from rural areas across the country, but what we have in common is that the needs far outstrip the resources available.

And Mr. Chairman, at this time, I would like to ask unanimous consent to place into the record Ranking Member Waxman's statement for this hearing today.

Mr. MURPHY. Without objection, thank you. We have a copy of that now. Thank you.

[The prepared statement of Mr. Waxman follows:]

PREPARED STATEMENT OF HON. HENRY A. WAXMAN

Mr. Chairman, I want to thank our witnesses for coming today. I appreciate Administrator Hyde being here, and I want to particularly thank Mr. Bruce for traveling here to share his tragic story. I appreciate his bravery in joining us. His story—and those we've heard from other families—is a powerful reminder of why this Committee needs to act to improve mental health services and treatment.

Mr. Chairman, I know how important this issue is to you. And I know that you are serious about improving mental health care in this country.

But I do worry about our progress. After the tragic Newtown massacre, I was hopeful about efforts to improve the mental health care system and make sure that those suffering from serious mental illnesses received the diagnoses and treatment that they need.

Six months later, I am much less confident. Since Newtown, Congress has done nothing to advance mental health proposals. In fact, we've lost ground.

Last week, the House voted to repeal the Affordable Care Act—the law that builds on bipartisan mental health parity efforts to extend mental health and substance use disorder benefits and parity protections for 62 million Americans.

And we have done nothing to fix sequestration, which represents a major reversal of progress. Mr. Chairman, the 2013 spending plan that SAMHSA released earlier this month shows that the sequester will result in cuts of over $200 million in SAMHSA funding this year—a cut of almost 6%.

Every single SAMHSA program will be affected. The Mental Health Block Grant program is being cut by $23 million. Children's Mental Health Services are cut by $6 million. Suicide prevention funds will be cut. Programs to help mentally ill people who are homeless will be cut.This will mean fewer SAMHSA grants and fewer people with access to mental health services.

According to Mental Health America, the sequester will mean that more than 1 million children and adults will be at risk of losing access to any type of public mental health support . almost 30,000 mentally ill, homeless people will lose access to primary care referral, housing assistance, and other important services . more than 11,000 professionals will lose access to youth suicide prevention training . and more than 1,500 at-risk youth will not be screened for mental health conditions.

The list goes on and on. These cuts are mindless. They represent an enormous step backward in our efforts to prevent, diagnose, and improve treatment for those with mental illnesses. And they are happening as we speak.

Mr. Chairman, this Committee needs to act. The sequester is creating a slow-motion crisis for those with mental illnesses, and we need to work together to end it.

But we should not only end the sequester—we should work together to strengthen our laws and improve funding so those suffering from serious mental illnesses are identified, receive better services, and achieve better outcomes.

This Subcommittee has done important work. Through our series of briefings, forums, and hearings, we have learned about what works and what doesn't, and where the funding and legislative gaps exist in our nation's mental health care system.

Now, Mr. Chairman, it's time for us to act together, in a bipartisan way, to fill those gaps and chart a new course in the provision of mental health services for those in need. I look forward to working with you and my colleagues to achieve those goals.

Mr. MURPHY. All right. I would now like to introduce the witness on the first panel for today's hearing. Our first witness is Pamela Hyde. She was nominated by President Barack Obama and confirmed by the U.S. Senate in November 2009 as administrator of the Substance Abuse and Mental Health Services Administration. Ms. Hyde is an attorney and comes to SAMHSA with more than 35 years of experience in management and consulting for public health care and human services agencies. She served as a state mental health director, state human services director, city housing and human services director, as well as CEO of a private nonprofit managed behavioral healthcare firm.

Welcome today, Ms. Hyde. Now, I will swear you in. As you are aware, the Committee is holding an investigative hearing. When doing so, we have the practice of taking testimony under oath. You have any objections to testifying under oath?

Ms. HYDE. No, sir.

Mr. MURPHY. And the chair then advises you that under the rules of the House and rules of the Committee, you are also entitled to be advised by counsel. Do you desire to be advised by counsel during your testimony today?

Ms. HYDE. No, thank you.

Mr. MURPHY. You probably can provide that for yourself then.

In that case, if you would please rise and raise your right hand, I will swear you in.

[Witness sworn.]

Mr. MURPHY. Thank you. You are now under oath and subject to the penalties set forth in Title XVIII, Section 1001 of the United States Code. You are now welcome to give a 5-minute summary of your written statement, Ms. Hyde.

TESTIMONY OF PAMELA S. HYDE, ADMINISTRATOR, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

Ms. HYDE. Thank you, Congressman Murphy and Ranking Member DeGette, for holding this hearing today. It is an important conversation and I am sure, as you are aware, you have already stated you know that SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

I would like to take just a few moments to remind you that SAMHSA is a small agency with a very big mission. While our funding is small, we use every opportunity to impact the public and private funders of mental health services. We collaborate and influence our sister agencies in HHS and across Federal Government, and we work with States, tribes, territories, communities, and stakeholders to help advance the behavioral health of the Nation.

SAMHSA has many roles. Funding is one of them but it is not the only one. We also provide leadership and voice for and about behavioral health issues, and that includes substance abuse. It also includes mental illness. It includes prevention, treatment, and recovery. We also do surveillance and data reporting. We provide funding, as we indicated, and we also work to improve practice with a number of materials and trainings, and we look at evidence-based practices, as well as practices coming to science. And we provide information to the public in the field, our public awareness and education responsibility, and we also have some responsibility for setting standards and regulations in certain areas.

I want to just make a quick comment about mental health financing because it goes to SAMHSA's role. The mental health spending for mental illness in our country was only about 6.3 percent of all health spending in 2009. That is far below the importance of mental health and mental illness in our healthcare issues. Mental health treatment spending depends much more on public payers than other kinds of health spending, about 60 percent of mental health spending compared to 49 percent of all health care spending.

For public spending, Medicaid and Medicare are by far the largest payers for services, and when you add their 40 percent to about 26 percent of private insurance, then insurance—Medicaid, Medicare, and private insurance—accounts for about 2/3 of mental health spending followed by state and local governments' out-of-pocket spending and then a small portion of federal spending, and that is where SAMHSA's dollars are. So our dollars are a fairly small part of that larger overall effort.

About 29 percent, as it was indicated earlier today, is SAMHSA's—it is about $3 billion—3 plus billion dollars, about 29 percent of it is for mental health. About 70 percent of it is for substance abuse. Of our mental health dollars, about 27 percent of our total budget is for mental health services, about 2 percent, give or take, is for surveillance data, public awareness, and other kinds of efforts. This distribution between substance abuse and mental health issues has been about the same for the last 5 years.

Within the mental health budget of SAMHSA, about half of it is block grant services, which is specifically for people with serious mental illness and young people with serious emotional disturbance, and the balance of SAMHSA's mental health budget provides support for a range of mental health prevention, treatment, and recovery support services, all as directed by Congress. Altogether, SAMHSA's mental health budget is spent on about—75 to 80 percent of it is spent on adults with SMI or children with SED, or serious emotional disturbance.

Congress has made significant investments as well in the prevention, emotional health development, and promotion in early intervention for mental health issues, and SAMHSA does administer some of those programs.

In a very short time that I have left, I just want to highlight a couple of programs. Our Mental Health Block Grant of course is about half of our mental health spending. It is a flexible but critical, important part for the States that primarily serves people with evidence-based approaches who are not otherwise covered by insurance or other efforts and who—or the services are not otherwise covered. So Medicaid, Medicare, private insurance may pay for the basics like medication, inpatient, those sorts of issues. The Mental Health Block Grant often supplements those services with other important and evidence-based approaches.

We also have some approaches such as our Children's Mental Health Initiative. It is a huge part of our program that has since 1994 served over 122,000 young people with serious emotional disorders with great results. We also have a program at about $43 million that is the National Child Traumatic Stress Network, and it has been in existence for about 10 years and has provided evidence-based approaches to dealing with young people with trauma.

Our Primary and Behavioral Health Integration Program is a program explicitly focused on the health of adults with serious mental illness and we have had major improvements in the health impacts for those individuals in that program. We also have a program for assistance for transition from homelessness, which primarily serves adults with serious mental illness or people with mental illness and co-occurring disorders who are homeless.

We also have a Youth Violence Prevention Program that Congress has provided resources for us to work on, and that federal grant program is designed to prevent violence and substance abuse among our Nation's youth, schools, and communities. We do a lot of that work in conjunction with education. We also have a major program, about $33 million, called LAUNCH, which is specifically for children aged 0 to 3—to 8 to try to work on prevention, early intervention.

We also do—and I want to make a point here because of what is going on in Oklahoma right now that one of the major issues that SAMHSA works on is disaster response and preparedness. So whether it is Tucson, Sandy Hook, Aurora, or major disasters and weather-related emergencies such as Oklahoma, we do a lot of response.

Mr. MURPHY. Sorry. If you could give your wrap-up now.

Ms. HYDE. I think I will end there and let you ask questions. Thank you very much.

[The prepared statement of Ms. Hyde follows:]

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Testimony Before the

The Energy and Commerce Subcommittee on Oversight and Investigations

"Examining SAMHSA's Role in Delivering Services to the Severely Mentally Ill"

May 22, 2013

Statement of Pamela S. Hyde, J.D.

Administrator

Substance Abuse and Mental Health Services Administration

U.S. Department of Health and Human Services

Good morning Chairman Murphy, Ranking Member DeGette and Members of the Subcommittee. Thank you for the opportunity to testify today about the mission and priorities of the Substance Abuse and Mental Health Services Administration (SAMHSA), including services for adults with serious mental illness and children with serious emotional disturbance. SAMHSA accomplishes its mission through partnerships, policies, products, and programs that build resilience, improve treatment, and facilitate recovery for people with or at risk for mental and substance use disorders.

SAMHSA's Role

SAMHSA was established in 1992 and is directed by Congress to effectively target substance abuse and mental health services to the people most in need of them and to translate research in these areas more effectively and more rapidly into the general health care system. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities. SAMHSA strives to create awareness that:

- Behavioral Health is essential for health;
- Prevention works;
- Treatment is effective; and
- People recover from mental and substance use disorders.

SAMHSA serves as a national voice on mental health and mental illness, substance abuse, and behavioral health systems of care. It coordinates behavioral health surveillance to better understand the impact of substance abuse and mental illness on children, individuals, and families as well as the costs associated with treatment. SAMHSA helps to ensure dollars are invested in evidence-based and data-driven programs and initiatives that result in improved health and resilience.

SAMHSA applies strategic, data-driven solutions to field-driven priorities. To this end, SAMHSA helps states, territories, and tribes build and improve basic and proven practices and system capacity by encouraging innovation, supporting more efficient approaches, and incorporating research-based programs and best practices into funded programs so they can produce measureable results. In addition, SAMHSA's longstanding partnerships with other Federal agencies, systems, national stakeholders, and the public have uniquely positioned SAMHSA to collaborate and coordinate across multiple program areas, collect best practices and develop expertise around behavioral health services, and, understand and respond to the full breadth of the behavioral health needs of children, individuals and families across the country.

Substance abuse, addictions, poor emotional health, and mental illnesses take a toll on individuals, families, and communities. These conditions cost lives and productivity, and strain families and resources in the same way as untreated as physical illnesses. SAMHSA works to focus the Nation's attention on these preventable and treatable problems.

Mental Health and Substance Abuse Data

Health surveillance is critical to SAMHSA's ability to develop new models of care to address substance abuse and mental illness. SAMHSA provides decision makers, researchers and the general public with enhanced information about the extent of substance abuse and mental illness, how systems of care are organized and financed, when and how to seek help, and about effective models of care, including the outcomes of treatment engagement and recovery.

It is estimated that almost half of all Americans will experience symptoms of a mental health condition – mental illness or addiction – at some point in their lives. Yet, today, less than one in five children and adolescents with diagnosable mental health problems receive the treatment they need.[1] And according to data from SAMHSA's National Survey on Drug Use and Health (NSDUH), only 38% of adults with diagnosable mental health problems – and only 11% of those with diagnosable substance use disorders - receive needed treatment.[2]

With respect to the onset of behavioral health conditions, half of all lifetime cases of mental and substance use disorders begin by age 14 and three-fourths by age 24.[3]

Currently, SAMHSA supports national surveys and surveillance, including the National Survey on Drug Use and Health, Drug Abuse Warning Network, and Drug and Alcohol Service Information System. SAMHSA also supports the behavioral health field by sharing information about evidence-based practices through tools such as the National Registry of Evidence-based Programs and Practices. SAMHSA also uses the Web, print, social media, public appearances, and the press to reach the public, providers and other stakeholders, including people in recovery and their families.

Practice Improvement

SAMHSA supports innovation and practice improvement by disseminating key evidence-based mental health and substance use practices, such as Treatment Improvement Protocols, Technical Assistance Publications, The National Registry of Evidence-based Programs and Practices, and evidenced-based toolkits, to the mental health and substance abuse delivery system and facilitates practice improvement by engaging in activities that support mental health system transformation and reform. One of SAMHSA's roles is to provide grants and contracts consistent with congressionally-appropriated funding. SAMHSA uses this crucial funding to create, test, and disseminate models of services and programs to improve the Nation's behavioral healthcare delivery systems as well as the promotion of mental health and the prevention of mental illness and addictions in children and adults. Additionally, SAMHSA holds policy academies for states, tribes and territories, provides technical assistance, training, and guidance

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[1] Unmet Need for Mental Health Care Among U.S. Children: Variation by Ethnicity and Insurance Status
Sheryl H. Kataoka, M.D., M.S.H.S.; Lily Zhang, M.S.; Kenneth B. Wells, M.D., M.P.H., Am J Psychiatry 2002;159:1548-1555. 10.1176/appi.ajp.159.9.1548

[2] Substance Abuse and Mental Health Services Administration, *Results from the 2011 National Survey on Drug Use and Health: Mental Health Findings*, NSDUH Series H-45, HHS Publication No. (SMA) 12-4725. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2012.

[3] Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of *DSM-IV* disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*(6), 593–602.

for the behavioral health field, supports innovation in evaluation and research, moves innovations and evidence-based approaches to scale, identifies and disseminates new and emerging practices from the field, and cooperates with national and international partners to identify promising approaches to supporting behavioral health.

Public Education and Awareness

Today in the United States, opportunities to prevent or intervene early to reduce disability and death associated with mental illness and substance use disorders are often missed. The tragedy at Sandy Hook Elementary School in December 2012 underscores the importance of educating the American people about mental health and what we can do to connect people in need with services. By learning to recognize the signs and symptoms of mental illness and substance abuse, friends and family members can help their loved ones take action and seek care. Trained health professionals can also work with individuals and families to identify problems early.

To help with its public education effort, SAMHSA supports public awareness campaigns, produces and distributes public education materials, releases data from its surveillance and data collection efforts, and increasingly uses electronic and social media to help disseminate information to the public and the field. By confronting fear and misunderstanding with facts, raising awareness about the effectiveness of prevention and treatment, and improving knowledge about when and where to seek help, SAMHSA helps bring mental illness and addictions out of the shadows and helps the nation achieve the full potential of the science behind the prevention and treatment of mental illnesses and substance abuse.

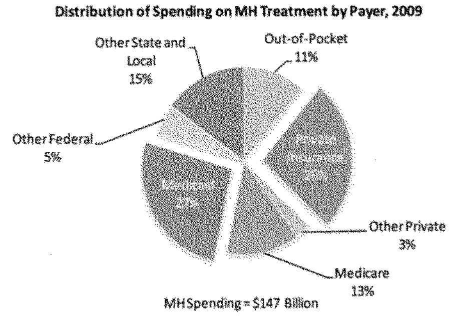
Policy Development and Oversight

SAMHSA protects and promotes behavioral health through regulation and standard setting. For example, SAMHSA works to prevent tobacco sales to minors through the Synar Program, administers the Federal drug-free workplace and drug-testing programs, oversees opioid treatment programs and accreditation bodies, informs physicians' office-based opioid treatment prescribing practices, and partners with other agencies at the U.S. Department of Health and Human Services in development and review of regulations and guidance documents affecting prevention, treatment and recovery support services that address mental health and substance abuse.

Overview of the Nation's Mental Health Spending

According to SAMHSA's *National Expenditures for Mental Health Services & Substance Abuse Treatment 1986 – 2009*, at $147 billion, mental health spending accounted for 6.3 percent of all health spending in calendar year 2009, while substance abuse spending accounted for approximately one percent. Mental health treatment spending depended more on public payers than spending for all-health care in calendar year 2009; public payers accounted for 60 percent of mental health spending compared to 49 percent of all-health care spending.

Medicaid and Medicare (40 percent) and private insurance (26 percent) accounted for approximately two-thirds of mental health spending in 2009, followed by state and local governments at 15 percent, out-of-pocket at 11 percent, other Federal spending at five percent (including SAMHSA funding), and other private sources at three percent.



SAMHSA's Budget

In FY 2013, approximately 29 percent ($957.7 million) of SAMHSA's funding was appropriated or designated for mental health programs and activities, with the remainder directed to substance abuse programs and activities. This distribution of funding between substance abuse and mental health has been consistent for the last five years. Of the SAMHSA mental health funding, most ($915.3 million) supports prevention, treatment and recovery support programs and activities within SAMHSA's Center for Mental Health Services (CMHS). In addition to the CMHS funding, a portion ($42.4 million) of SAMHSA's funding for the Health Surveillance and Program Support (HSPS) programs is used for the mental health activities.

Center for Mental Health Services (CMHS)

Approximately 48 percent ($436.81 million) of CMHS funding is directed toward the Community Mental Health Services Block Grant, which provides services and supports for adults with serious mental illness[4] and children with serious emotional disturbance.[5]

The balance of the CMHS budget (52 percent) provides support for a range of mental health prevention, treatment and recovery support services as directed by Congress. In FY 2013, approximately 81 percent of the CMHS budget will support adults with and at risk for serious mental illness and/or children with serious emotional disturbance.

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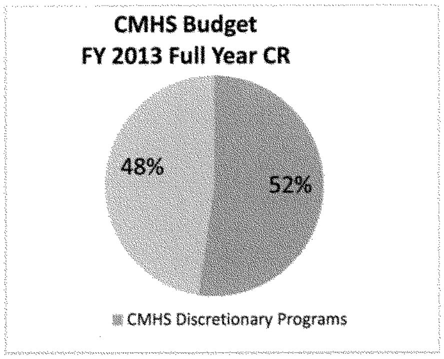
[4] Pursuant to Section 1912(c) of the Public Health Service Act, SAMHSA's definition of SMI can be found at: http://www.samhsa.gov/healthreform/healthhomes/Definitions_SIM_SUD_508.pdf.

[5] Pursuant to Section 1911(c) of the Public Health Service Act, SAMHSA's definition of SED can be found at: http://www.samhsa.gov/healthreform/healthhomes/Definitions_SIM_SUD_508.pdf.

Within the CMHS budget over the last five years, 75-80 percent of appropriated funding has been used for mental health programs in support of adults with serious mental illness and children with serious emotional disturbance.



Examples of SAMHSA Programs with National Impact

To accomplish its work, SAMHSA administers a combination of competitive discretionary programs and block grant programs. This portfolio provides states and communities with support to establish or expand organized community-based systems of care for children with serious emotional disturbances and adults with serious mental illness through training, technical assistance, and provision of evidenced-based clinical and recovery support services.

Community Mental Health Services Block Grant

The Community Mental Health Services Block Grant is a key source of funding for community-based services for adults with serious mental illness and children with serious emotional disturbances. In Fiscal Year (FY) 2013, $408.9 million, was awarded to states through the Community Mental Health Services Block Grant. It is a flexible funding source used by states to provide a range of mental health services and system infrastructure and capacity supports. States use these limited but significant funds to support planning, administration, evaluation, educational activities, and direct service delivery. Services typically are for those not covered by Medicaid, insurance or other sources, and for services not otherwise covered, and include rehabilitation services, crisis stabilization and case management, peer specialist and consumer-directed services, wrap around services for children and families, supported employment and housing, jail diversion programs, and services for special populations. By law, states are not allowed to utilize these funds for inpatient services.

Each state's Community Mental Health Services Block Grant application is based on a plan developed in collaboration with state mental health planning councils, which are required in order to receive block grant funding. Planning councils' membership is statutorily mandated to include consumers, family members of adult and child consumers, providers, and representatives of other principal state agencies delivering, paying for, or impacting mental health services.

The Community Mental Health Services Block Grant supports services and infrastructure for state mental health authorities that serve almost seven million adults with serious mental illness and children with serious emotional disturbance.

SAMHSA has placed a strong emphasis on ensuring that Block Grant funds are expended in a manner consistent with the statutory and regulatory framework, including providing states the flexibility to address service needs and approaches they believe are most critical for the populations of adults with serious mental illness and children with serious emotional disturbances. Currently, the primary goals of SAMHSA program integrity efforts are to: (1) promote the proper expenditure of Block Grant funds; (2) improve Block Grant program compliance nationally; and (3) demonstrate the effective use of Block Grant funds, including using National Outcomes Measures such as readmission to any state psychiatric hospital within 30 days and 180 days; proved functioning; and employment status.

Children's Mental Health Initiative

The Children's Mental Health Initiative (CMHI) provides $111.4 million in FY 2013 to states and communities to support the development of comprehensive, community-based systems of care for the estimated nine to 13 percent of children and youth with SED and their families. A system of care is a strategic approach to the delivery of services and supports that incorporate family-driven, youth-guided, strength-based, and culturally and linguistically competent care in order to meet the physical, intellectual, emotional, cultural, and social needs of children and youth.

CMHI has served over 120,000 children and youth with serious emotional disturbance since the inception of the program. Data from the CMHI National Evaluation demonstrates that the system-of-care approach is effective. For example, school attendance and performance improves, behavioral and emotional strengths are increased, and children and youth have more stable living conditions. Within six months of service in CMHI, the number of youth reporting suicide attempts or thoughts of suicide decreased. And, there were decreased contacts with law enforcement. Specifically, for youth involved in the juvenile justice system, arrests decreased by nearly 50 percent from intake into the program after 12 months of service in CMHI.

The National Child Traumatic Stress Network

Through the National Child Traumatic Stress Initiative (NCTSI), SAMHSA supports a national network of grantees—the National Child Traumatic Stress Network (NCTSN)—that works collaboratively to develop and promote effective trauma treatment, services and other resources for children and adolescents exposed to an array of traumatic events. The NCTSN Centers collaborate to develop, implement, and evaluate effective trauma screening, treatment and services, and partner with other community agencies to promote service delivery approaches so that trauma services are effectively implemented within local child-serving community service systems.

To date, NCTSI has developed and implemented 20 effective interventions to reduce immediate distress from exposure to traumatic events, developed and provided training in trauma-focused services for use in child mental health clinics, schools, child welfare and protective services, among other service areas; and developed widely used intervention protocols for disaster victims. In FY 2012, 2,367 children and adolescents received trauma-informed services through the NCTSI program, and over 121,310 people were trained in annual training education events. In the same year, 76.1 percent of children receiving trauma-informed services reported positive functioning at six-month follow-up.

Primary and Behavioral Health Integration

SAMHSA administers the Primary and Behavioral Health Care Integration (PBHCI) program. The purpose of the program is to improve the physical health status of adults with serious mental illness by supporting communities to coordinate and integrate primary care services into publicly funded community mental health and other community-based behavioral health settings. The program supports community-based behavioral health agencies' efforts to build the partnerships and infrastructure needed to initiate or expand the provision of primary healthcare services for people in treatment for serious mental illness and co-occurring serious mental illness and substance use disorders.

Since September 2009, the program has awarded 94 grants, and 55 percent of awardees are partnering with at least one Federally Qualified Health Center (FQHC). The Health Resources and Services Administration (HRSA) and SAMHSA collaborate to fund a national technical assistance center to help these grantees and FQHCs integrate primary and behavioral health care in both types of settings. This integration of care and agency efforts has resulted in significant physical and behavioral health gains as well as reduced health care expenditures. Some results that are based on grantee-reported outcome measures from February 2010 through January 7, 2013, include:

- Health: The percentage of consumers who rated their overall health as positive increased by 20 percent from baseline to most recent reassessment (N=3737).

- Tobacco Use: The percentage of consumers who reported they were not using tobacco during the past 30 days increased by 6 percent from baseline to most recent reassessment (N=3787).

- Illegal Substance Use: The percentage of consumers who reported that they were not using an illegal substance during the past 30 days increased by 12 percent from baseline to most recent reassessment (N=3568).

Projects for Assistance in Transition from Homelessness

The Projects for Assistance in Transition from Homelessness (PATH) is a unique program that is specifically authorized to address the needs of individuals with serious mental illness and/or serious mental illness with a co-occurring substance use disorder who are experiencing homelessness or are at risk of homelessness. PATH funds community-based outreach, mental health, substance abuse, case management and other support services, as well as a limited set of housing services to connect homeless individuals to housing services and support them in community housing settings. In the past 5 years, the PATH program has reached approximately 170,000 individuals each year, with an average of about 68,000 of those individuals becoming enrolled in the PATH program each year.

Youth Violence Prevention

The Safe Schools/Healthy Students program is a unique Federal grant program designed to prevent violence and substance abuse among our nation's youth in schools and communities. Since 1999, this program has been jointly administered and supported by SAMHSA and the Departments of Education and Justice. The Safe Schools/Healthy Students initiative implements an enhanced, coordinated, and comprehensive plan of activities, programs, and services that promote healthy childhood development, prevent violence, and prevent alcohol and drug abuse. A key element of Safe Schools/Healthy Students activities is the expansion of school-based mental health services, as well as referral to treatment to community health providers. SAMHSA is in the process of completing a national cross-site evaluation of Safe Schools/Healthy Students. Preliminary findings include:

- The program has seen significant increases in the number of students who received school-based mental health services, and community-based services.

- Nearly 90 percent of school staff stated that they were better able to detect mental health problems in their students and more than 80 percent of school staff reported that they observed reductions in alcohol and other drug use among their students.

- Over 90 percent of school staff saw reduced violence on school grounds and nearly 80 percent reported that Safe Schools/Healthy Students had reduced violence in their communities.

President's *Now is the Time* Initiatives

In addition to the programs discussed above, I would like to share some of the initiatives related to mental health included in the President's proposed plan, *Now is the Time,* which emphasizes early intervention and treatment for young people struggling with mental health problems.

On January 16, 2013, the President announced his plan to ensure that students and young adults receive treatment for mental health issues. These proposals are included in the President's FY 2014 Budget. Specifically, SAMHSA will take a leadership role in initiatives that would:

1. Reach 750,000 young people through programs to identify mental illness early and refer them to treatment: To support training for teachers and other adults who regularly interact with students to recognize young people who need help and ensure they are

referred to mental health services, the Administration has proposed a new initiative, Project AWARE (Advancing Wellness and Resilience in Education), to provide this training and set up school-community partnerships to promote mental health, and facilitate referrals when needed. This initiative, which will be coordinated with related proposals at the Departments of Justice and Education, has two parts:

a. **Provide "Mental Health First Aid" training for teachers:** Project AWARE proposes $15 million for training for teachers and other adults who interact with youth to detect and respond to mental illness, including how to encourage adolescents and families experiencing these problems to seek treatment.

b. **Ensure students with signs of mental illness get referred to treatment:** Project AWARE also proposes $40 million to help states and school districts work with community leaders, law enforcement, mental health agencies, families and youth, and other local organizations to assure students with mental health issues or other behavioral issues are referred to and receive the services they need. This initiative builds on strategies that, for over a decade, have proven to decrease violence in schools and increase the number of students receiving mental health services.

2. Support individuals ages 16 to 25 at high risk for mental illness: The Administration is proposing $25 million for a new initiative, Healthy Transitions, to support innovative state-based strategies to support young people ages 16 to 25 with mental health or substance abuse issues. Efforts to help youth and young adults cannot end when a student leaves high school. Individuals ages 16 to 25 are at high risk for mental illness, substance abuse, and suicide, but they are among the least likely to seek help. Even those who received services as a child may fall through the cracks when they leave school or turn 18.

3. Train more than 5,000 additional mental health professionals to serve students and young adults: Experts often cite the shortage of skilled mental health service providers as one reason it can be hard to access treatment. To help fill this gap, the Administration is proposing $50 million to train social workers, counselors, psychologists, behavioral health paraprofessionals, marriage and family therapists, nurses, and other mental health professionals. This would allow SAMHSA and HRSA to provide financial support to train more than 5,000 mental health professionals to serve children, adolescents, young adults (including individuals aged 16-25 years old), and their families, in our schools and communities.

As part of his plan to reduce gun violence, President Obama directed Secretaries Sebelius and Duncan to launch a national conversation to increase understanding and awareness about mental health. As part of that effort, on June 3rd, the President and Vice President will host a National Conference on Mental Health. The conference will bring together people from across the country, including mental health advocates, educators, health care providers, faith leaders, and individuals who have struggled with mental health problems, to discuss how we can all work together to reduce negative attitudes, and help the millions of Americans struggling with mental health problems recognize the importance of reaching out for assistance.

In addition to these initiatives where SAMHSA is taking a leadership role, other offices in the Department of Health and Human Services have been taking steps – as outlined in the President's *Now Is the Time* plan, to expand coverage of mental health services. Additionally, the Department of Education has proposals to help 8,000 schools create safer and more nurturing school climates and address pervasive violence.

Ensuring Efficiencies and Effectiveness

Evaluation, Outcomes and Quality

SAMHSA has a long history of conducting evaluations designed to ascertain information about programs funded with Federal dollars. More recently, SAMHSA has embarked upon a course to enhance the rigor of its evaluations in order to use data to examine the effectiveness of programs, the quality of program implementation, and to better understand how certain interventions or activities influence behavioral health outcomes in communities across the nation. To this end, SAMHSA evaluations are examined to ensure that the methods are appropriate to the evaluation questions and that the right data is collected to inform our understanding of the results of programs.

Recently SAMHSA completed an inventory of all evaluations currently ongoing in the agency. These evaluations will be closely monitored by evaluation staff and will be strengthened where indicated and possible. These evaluation experts are collaborating with program staff to develop reporting mechanisms to ensure that the data collected in an evaluation are used to inform policies and practices for the future.

SAMHSA has also undertaken to develop a National Behavioral Health Quality Framework (NBHQF), modeled after the National Quality Strategy, to guide behavioral health services and programs throughout the country and to provide a consistent set of validated measures at the payer, practitioner/program and population levels. The six goals articulated by the NBHQF are: (1) effective services; (2) person-centered care; (3) effective care coordination; (4) use of best practices; (5) safe care; and (6) accessible and high-value care. The draft NBHQF will soon be in its third round of public input with expected release later this year.

SAMHSA Stewardship

SAMHSA takes its role as a steward of taxpayer dollars seriously. SAMHSA has closely examined its portfolio to find efficiencies and as a result has reduced redundancy or duplication of programs. For example, in 2012, SAMHSA evaluated its contracting process to achieve purchasing efficiencies and leverage similar contracting vehicles. As a result, SAMHSA consolidated three state technical assistance contracts into a single contract resulting in both programmatic as well as administrative efficiencies. In 2011, several similar consolidations took place. SAMHSA constantly evaluates its programs via review of grantee performance and data collection. Program adjustments, in scope or focus, are directly affected by that data.

Technical Assistance

Technical assistance is a key activity provided by SAMHSA in order to ensure that systems, services, and programs are delivered in the most effective and efficient way possible, and to lead the field toward the use of processes and practices that obtain the best outcomes. SAMHSA provides technical assistance not only to its grantees for the implementation of specific grant programs but also to the field at large for system-wide change and enhancement. SAMHSA's technical assistance is provided through staff subject matter experts as well as through a combination of grants and contracts for technical assistance centers and independent organizations that are managed by SAMHSA staff. The provision of technical assistance encompasses a series of strategies, processes, techniques, and activities (*e.g.*, training, consultation, expert guidance, etc.) designed to maximize overall performance and result in improved outcomes. SAMHSA has developed principles to guide its technical assistance efforts. This approach ensures that SAMHSA's technical assistance activities are delivered in the most effective and efficient way possible, leading the behavioral health field toward the use of processes and practices that obtain the highest level of outcomes.

Conclusion

We have made important strides in the prevention, treatment, and recovery supports for mental and addictive disorders. However, much work remains to be done. The Administration continues to advance our work on this important issue and we look forward to continuing to work with the Congress on these efforts.

Mr. MURPHY. Thank you so much for being here today and for your work.

I want to just clarify a couple things. I note your testimony in written and oral states several times that SAMHSA supports evidence-based programs and practices and even data-driven solutions. So does this mean SAMHSA requires evidence and data before making a grant award?

Ms. HYDE. Congressman Murphy, thank you for the question. Yes, we require in our request for applications we ask individuals either to use an evidence-based practice that we have identified or to tell us what approach they propose to use and to explain to us how they think that it has evidence behind it or how it is moving into science as they are developing evidence of it working for them.

Mr. MURPHY. Do you use models like NIH has where there are professionals, experts in the field with advanced degrees who are the majority of panelists to review grants?

Ms. HYDE. That is correct. We use experts to do those reviews.

Mr. MURPHY. By experts, I mean people with MDs or PhDs who have the scientific credentials as the majority of panelists in each grant review?

Ms. HYDE. Each of the grant reviews use people who are experienced in that area. What their degrees are, I don't have that in front of me.

Mr. MURPHY. Experience, I am talking about the majority of the panelists. This is a yes or no. Are the majority of panelists people who have specific advanced training and academic and professional credentials in those fields versus just experience?

Ms. HYDE. They have training and experience. I do not have with me what their degrees are.

Mr. MURPHY. I am just asking is the policy of SAMHSA that the majority of people reviewing grants have advanced degrees and academic credentials and license credentials in reviewing these grants?

Ms. HYDE. It is our policy, Congressman, to have individuals with the experience and——

Mr. MURPHY. But that is a no? It sounds like——

Ms. HYDE. I will repeat——

Mr. MURPHY [continuing]. That is a no.

Ms. HYDE [continuing]. That I don't have with me and I don't have the information about what their degrees——

Mr. MURPHY. OK. That would be a major issue because that is a major part of your work. Do you fund competitive or discretionary grants that are part of the mission of SAMHSA or do you also fund grants that run diametrically opposed to the mission of SAMHSA?

Ms. HYDE. I think all of our grants and all of our efforts, whether grant-based or not, are working toward our mission.

Mr. MURPHY. OK. Thank you. What is the evidence that SAMHSA used to fund an advocacy group that encourages the mentally ill not to take their medication?

Ms. HYDE. I am sorry, Congressman. Can you repeat the question?

Mr. MURPHY. I just wonder what evidence did you use as the decision-making process when you fund advocacy groups that encourages the mentally ill not to take the medication?

Ms. HYDE. I don't think we fund advocacy efforts explicitly to tell people not to take the medication.

Mr. MURPHY. You just told me that you don't fund things that run counter to your mission, and we will here today from people who have evidence that SAMHSA does fund organizations that encourage people not to take their psychiatric medication. So I am just wondering what the evidence is that SAMHSA relied upon to fund such a grant.

Ms. HYDE. We fund lots of organizations who have missions or who have opinions or value bases that may not necessarily agree with SAMHSA or with the field. What we fund are specific grants for specific purposes related to the mission of SAMHSA.

Mr. MURPHY. I still want to know, and we are going to continue to pursue this because it is an important issue. And I note in your testimony you do not even mention the title psychiatrist, and as I noted in my opening statement, you don't mention the words bipolar, schizophrenia, or other forms of severe mental illness to talk about a lot of things. And many of those things are good, but we are here today to talk about severe mental illness. Does SAMHSA acknowledge that there was a scientific evidence basis provided by SAMHSA's sister public health agencies such as NIH and the FDA that support the effectiveness of medical treatment for mental illness?

Ms. HYDE. Absolutely, Congressman. We work closely with NIMH, with NIDA, with NIAAA, with other institutes within NIH, with FDA, and other agencies and we work hard to take what they learn from the research and use it in the efforts that we do.

Mr. MURPHY. One of those that you fund is the National Empowerment Center whose director espouses anti-science, anti-psychiatry views and your agency also funds the alternatives, which is that in your workshop or symposium which regularly features workshops and speakers who advised people with serious mental illness to go off physician-prescribed medication.

And as I said before, your testimony today does not even mention the psychiatry or get into medication issues. So I once again want to know where is the evidence that this approach to treating severe mental illness has any scientific, evidence-based, data-driven background that would support what you continue to fund?

Ms. HYDE. Congressman, there are a number of ways to provide treatment and services, and we fund a number of conference efforts and others. We do not go inside each individual presentation to identify whether or not we agree with each individual——

Mr. MURPHY. But you continue to fund it——

Ms. HYDE [continuing]. Presenter——

Mr. MURPHY [continuing]. And you oftentimes speak at an opening or part of those conferences?

Ms. HYDE. Yes, we do, and we fund other conferences for the American Psychological Association, for ASAM, for other organizations also that we don't look at every single presentation——

Mr. MURPHY. I mean yes or no, is it medically possible to prevent the onset of schizophrenia?

Ms. HYDE. I think the biomarkers are not there yet. I think NIMH is working hard on biomarkers about that. We know that we can prevent a lot of the salient conditions about schizophrenia and we know that there are a number of people with schizophrenia who can in fact get to a point where they are living without the symptoms of the illness that they first experienced.

Mr. MURPHY. Thank you. Thank you. Ms. DeGette, 5 minutes.

Ms. DEGETTE. Let try to clear some of this up, Administrator Hyde. It is not in the mission of SAMHSA to tell patients not to take their medication, is that correct?

Ms. HYDE. That is correct. We——

Ms. DEGETTE. OK. So what happens is Congress has mandated that some of the groups that SAMHSA fund are patient advocacy groups, correct?

Ms. HYDE. That is correct.

Ms. DEGETTE. And some of those patient advocacy groups may in fact tell their people not to take drugs, is that correct?

Ms. HYDE. They very well may.

Ms. DEGETTE. And that is not SAMHSA's policy; that is those groups' policy, right?

Ms. HYDE. Those groups may have that policy.

Ms. DEGETTE. And so really Congress should look at do we want to be telling SAMHSA to fund patient advocacy groups, right?

Ms. HYDE. It is certainly a congressional authority and a congressional program——

Ms. DEGETTE. The other issue is a great amount of the money that SAMHSA spends is block granted to the States, is that right?

Ms. HYDE. That is correct.

Ms. DEGETTE. And so once those funds go to the State, then the governors decide how those funds are going to be spent and SAMHSA doesn't really exercise discretion over the groups that the States give those block grants to, right?

Ms. HYDE. That is correct. We have a plan that the State provides to us——

Ms. DEGETTE. Right.

Ms. HYDE [continuing]. But the State makes that decision.

Ms. DEGETTE. Right. So that is, again, something else Congress should look at is do we really want to be just sending that money to the States without the scientific control of where those funds go, right?

Ms. HYDE. Correct. And we do ask them to do evidence-based practices and data-driven processes.

Ms. DEGETTE. Of course you do. Now, let me ask you this because you talked quite a bit in depth in your opening about the percentages of SAMHSA's budget that go to mental health versus drug control and so on, and that again Congress has made those requirements on SAMHSA, right?

Ms. HYDE. That is our——

Ms. DEGETTE. I mean, it is not you that sits there and says I am going to spend 27 percent of my money on serious mental health; it is Congress that says that, right?

Ms. HYDE. That is correct.

Ms. DEGETTE. OK. Now, I read the testimony of the second panel and some of those witnesses—I am sure you have read it, too—they have strong criticisms of SAMHSA and I want to ask you about it. Dr. Torrey says that serious mental illness has a very low priority at the Agency because in the 3-year planning document that you have, there is no mention of a number of conditions. So I want to ask you a question. Does the Agency have a very low priority for serious mental illness?

Ms. HYDE. No. As I indicated, about 75 to 80 percent of our mental health dollars go towards substance abuse—I mean, excuse me—toward serious mental illness and serious emotional disturbance.

Ms. DEGETTE. And so why in that document did you not specifically mention schizophrenia, schizoaffective disorder, bipolar, severe depression, or obsessive compulsive disorder.

Ms. HYDE. That planning document is about behavioral health systems and directions that we are taking and it has to do with developing quality frameworks and developing public awareness and approaches. It has to do with prevention and a number of other things. We don't have any references to any diagnoses in that particular——

Ms. DEGETTE. Oh, I see. OK. So it is just because of the nature of that document——

Ms. HYDE. That is correct.

Ms. DEGETTE [continuing]. Not because there is not an emphasis. Now, Dr. Torrey also says—and this is a quote from his testimony—"nobody among SAMHSA's 574 staff has experience in severe mental illness." Is that true?

Ms. HYDE. No.

Ms. DEGETTE. Why do you say that?

Ms. HYDE. Because we have a number of people ranging from social work, psychologists, internists and others who work—have been working in this field for years in these areas, so they have extensive experience.

Ms. DEGETTE. And now, is it true that SAMHSA has only employed one psychiatrist?

Ms. HYDE. We don't employ a lot of psychiatrists. We are not the direct provider of services like IHS or others. We did actually just announce this week—we have been working on it for 2 years—we announced the arrival on June 3 of our chief medical officer, who is a psychiatrist and will be joining——

Ms. DEGETTE. So what you saying is because you are not focusing on actual treatment, you don't feel you necessarily need people with those credentials for every position?

Ms. HYDE. Not for every position——

Ms. DEGETTE. OK.

Ms. HYDE [continuing]. Absolutely not.

Ms. DEGETTE. Now, I want to ask you what is the impact on SAMHSA's budget by the sequester and what are you anticipating for fiscal year 2014?

Ms. HYDE. The sequester results in about $168 million reduction in our programs. It was required that we take it across all programs so it didn't matter which ones. We had to take it against all of them. We expect or anticipate that that will result in about 330,000 less people getting services——

Ms. DEGETTE. Wow.

Ms. HYDE [continuing]. And the benefits of SAMHSA's programs. So it will significantly reduce that. For 2014 the President's budget proposes to undo the sequester and so to take us back to a point where we have more funding for services and programs, and he also proposes new funding and services as a result of what we have learned in our efforts out of the Sandy Hook effort.

Ms. DEGETTE. Thank you very much.

Mr. MURPHY. I recognize the gentleman from Texas, Dr. Burgess, for 5 minutes.

Mr. BURGESS. I thank the chair for the recognition. I am sorry I had to step out for a moment. I had a group of doctors out there I was talking to. But it brings up a good question. How many people work in your agency?

Ms. HYDE. Congressman Burgess, about 600 people, give or take.

Mr. BURGESS. And of that cadre of 600 individuals, how many M.D. psychiatrists are working?

Ms. HYDE. We have one. We also have a number of——

Mr. BURGESS. I found one on the internet, so good, we are aligned.

Ms. HYDE. We just announced the arrival on June 3 of our chief medical officer, which we have been seeking for a couple years. She arrives and will start and she is a psychiatrist in addiction psychiatry, board-certified.

Mr. BURGESS. So if I have it correct, I mean you are the mental health agency and substance abuse agency for the entire country, and up until a week or two ago, you had one psychiatrist on your staff?

Ms. HYDE. As I said—you might have been out of the room, but I did say that, yes, we don't do direct services. That is not what our charge is so we have a number of psychologists, social workers, counselors, other behavioral health professionals, addictionologists, and others in addition to other professions that we need to do our work.

Mr. BURGESS. Yes, but just speaking from someone who has spent a life in clinical practice, I mean, there is no substitute for that. Yes, I am in a position now where public policy is all that I think about, but at the same time, it is that time spent in the clinical practice of medicine that informs the policy, and your agency, it just strikes me we are really thin there. Is that a fair assessment?

Ms. HYDE. Given what our charge is and what we do and to be quite honest with you what we are able to pay, we have had a difficult time achieving any higher percentages of those individuals. We do have internists and others who work in other areas where it requires that kind of clinical expertise in order to do the program. We have, as I said earlier, a number of other behavioral health professionals who do work in our grant programs, and then we have people like statisticians and accountants and others who do other parts of our programs.

Mr. BURGESS. And all those people are important, but again, I would just submit that there is no substitute for someone who has spent time in the clinical realm of practicing medicine. I am not a psychiatrist but I know that because of that time in clinical medicine, someone who has practiced psychiatry is going to be invaluable to your agency as far as informing the policy and one or two folks aren't going to get it in an agency as large as yours with the enormous footprint that you have in the country as regards to mental health services.

Now, I accept the part about psychiatrists are expensive. I have always thought they have been overvalued, but we can get into that discussion later on. But, you know, you are talking now about you need to train additional people in the mental health services, correct, in SAMHSA?

Ms. HYDE. In conjunction with HRSA, that is correct.

Mr. BURGESS. And about how many?

Ms. HYDE. The President's proposal for 2014 would produce about 5,000 more professionals.

Mr. BURGESS. And of that 5,000 what is the cohort of clinical psychiatrists that would be part that?

Ms. HYDE. In that particular cohort, that is not what it is directed towards. HRSA's programs are directed more toward those clinical-level individuals.

Mr. BURGESS. Well, with all due respect to the President, he has never practiced clinical medicine either and I think that is apparent from the state of healthcare in this country today. But nevertheless, you need to have the expertise of someone who has accepted the responsibility for diagnosing and treating patients, following through on a treatment plan, and lacking that, it is hard to know how to advise you to do your job better. Without the basic tool, without that basic person involved at the clinical level, I just don't know how you deliver on the promise that you are supposed to do.

Now, my understanding is that years and years and years ago Congress in its wisdom separated out the research side from what you do, is that correct?

Ms. HYDE. That is correct.

Mr. BURGESS. So the research goes on at the National Institute of Health, but without a clinical psychiatrist on the staff, it is hard for me to know how you are going to be able to evaluate those things that are developed by that great research institution up north of town and make them applicable to the people who are suffering that you are supposed to be taking care of.

Ms. HYDE. Well, I have two comments about that, as I said earlier, we spent a couple of years and finally were able to recruit a new clinical psychiatrist to be the chief medical officer to do that kind of consultation. We also work very closely with Tom Insel and all of his staff at NIMH on issues about clinical care and about evidence-based practices.

Mr. BURGESS. Well, look, the President has announced a big brain mapping initiative, but without the people there to deliver the goods, I am afraid it is an empty promise.

Mr. Chairman, thank you. I will yield back.

Mr. MURPHY. Mr. Butterfield, you are recognized for 5 minutes.

Mr. BUTTERFIELD. Thank you very much, Mr. Chairman. And I am going to try to get through this very quickly.

Again, thank you for your testimony. Let's talk a little bit about sequestration. You mentioned it just a few moments ago. Did I understand you to say that it is had a $168 million impact on your agency?

Ms. HYDE. That is correct.

Mr. BUTTERFIELD. That is in fiscal year 2013?

Ms. HYDE. Correct.

Mr. BUTTERFIELD. And what is the projection, if you know, for 2014 and beyond?

Ms. HYDE. I don't know explicitly. My understanding is that it would probably result in somewhere like another 2 or 2–1/2 percent reduction but we don't have those numbers finalized.

Mr. BUTTERFIELD. And that translates into some 300,000 people or more?

Ms. HYDE. Just for 1 year, correct.

Mr. BUTTERFIELD. All right. Now, the House Labor HHS Appropriations Subcommittee has proposed an 18 percent cut. Are you aware of that?

Ms. HYDE. I have heard that.

Mr. BUTTERFIELD. And that translates into some $624 million. What impact would that proposal have on providing care to individuals with serious mental health illness?

Ms. HYDE. Well, it would—Congressman, it would have a profound impact. Just on our agency alone it would have a profound impact, not to mention on all the other agencies that provide services.

Mr. BUTTERFIELD. The Affordable Care Act has provided young adults with access to health insurance through their parents' plans, and that is a good thing, and it will provide people with access to health insurance in 2014 when the exchanges actually go into effect. With the full implementation of the Affordable Care Act in 2014, will it increase the ability of people to access mental health care?

Ms. HYDE. Absolutely. And about 62 million people will have access to coverage for mental and substance abuse disorders that don't have it now by a combination of the Affordable Care Act and the Mental Health Parity and Addiction Equity Act. And of those 62 million, we anticipate that about 11 million of them have mental health and substance abuse issues.

Mr. BUTTERFIELD. I am encouraged that SAMHSA has helped assist disadvantaged communities through discretionary grants. And as you may know, I represent a rural congressional district in North Carolina where nearly 1 in 4 people are below the poverty level. Can you describe for me some of the programs that SAMHSA has which are effective in addressing mental health in rural and low-income communities?

Ms. HYDE. Congressman, rural areas, I think, do have higher levels of—sometimes have higher levels of poverty. They have often less workforce available, so less people to provide those services. We have worked hard with HRSA and their rural program to try to see how we can stretch that workforce, how we can do telemedicine and other kinds of approaches for rural areas and then our Mental Health Block Grants obviously provide to the States dollars that they can use as they see fit. So for States with a higher rural proportion, they certainly could do that.

I come from the State of New Mexico. I understand the rural areas out there. And the block grant is an important part of that effort.

Mr. BUTTERFIELD. Thank you. North Carolina is home to more than 700,000 veterans and has one of the largest veteran populations in the entire country. Seymour Johnson Air Force Base in my district and both the Coast Guard station and the Marines have installations who have supported us. Can you describe some of the crucial programs that SAMHSA supports for returning service members and their families?

Ms. HYDE. Thanks for that question. Yes, we have had—in fact, in that Leading Change document we were just talking about earlier, military personnel and veterans is a huge priority for us. We have done everything from Policy Academies, helping States really get their arms around how they can provide services for those individuals. We support and work very closely with the Veterans Administration on suicide prevention efforts and our international lifeline is tied to them electronically. We have incorporated military families and veterans as a priority population within about half of our funding requests. We have really put a major effort there.

Mr. BUTTERFIELD. And can these programs be affected by sequestration?

Ms. HYDE. Absolutely.

Mr. BUTTERFIELD. It is my understanding that SAMHSA provides support to state mental health agencies on the ground in the wake of natural disasters. In the last year, my district was dramatically impacted by two hurricanes. Most recently, we have seen terrible destruction out in Oklahoma where I was on Tuesday of last week where the total impact won't be known for quite some time. Can you describe the important work that SAMHSA does with the relationship to the storms?

Ms. HYDE. Yes. Our disaster preparedness and response efforts have become very well-known. To FEMA, to the Red Cross, and to others we provide a 24/7 disaster distress helpline that is available anytime there is a major disaster like this. It is available all over the country but we target it to the area that is hit. We have all kinds of materials that help people know how to work through disaster issues and prepare psychologically for them. We do training and technical assistance for first responders——

Mr. BUTTERFIELD. Let me interrupt you because I am going to have to get this last question in——

Ms. HYDE. Absolutely.

Mr. BUTTERFIELD [continuing]. And it is important. I think you will agree. It is my understanding that for many insurance companies, preexisting conditions include any conditions which a patient has been treated for in the last 6 months. Under the Affordable Care Act, insurance companies cannot deny coverage due to preexisting illnesses. Our mental illnesses currently considered a preexisting condition by insurance companies?

Ms. HYDE. In many insurance companies, they are.

Mr. BUTTERFIELD. Once the law is implemented, will more individuals with mental health issues and now have access to care under the Act?

Ms. HYDE. Yes.

Mr. BUTTERFIELD. Thank you. Thank you, Mr. Chairman.

Mr. MURPHY. Thank you. We now recognize the gentlelady from Tennessee, Mrs. Blackburn, for 5 minutes.

Mrs. BLACKBURN. Thank you, Mr. Chairman, and we thank you for being with us today. I want to ask you a little bit about this

Alternatives Conference out in Portland, Oregon. You gave the keynote address at the conference in October 2012, is that correct?

Ms. HYDE. That is correct.

Mrs. BLACKBURN. OK. Would you mind submitting a copy of your remarks for us? Would that be possible?

Ms. HYDE. Congresswoman, I would be happy to. I don't usually have prepared text. I usually do overheads but I will give them to you.

Mrs. BLACKBURN. OK. That would be awesome. And you all sponsored that. I have got a copy of the program; I see you all sponsored this. This is one of your initiatives, correct?

Ms. HYDE. It is one of the many conferences and meetings we support, that is correct.

Mrs. BLACKBURN. OK. And I would assume in page 11 of your written testimony you talk about SAMHSA's stewardship, and since you brought up the sequestration a couple of times, my assumption is you are reviewing your sponsorship of such activities. Would that be right?

Ms. HYDE. We have been reviewing our sponsorship of all conferences and meetings, and in some cases we are continuing them but with reduced effort.

Mrs. BLACKBURN. OK.

Ms. HYDE. In other cases, we are just not doing them at all.

Mrs. BLACKBURN. How much did you spend to sponsor this conference?

Ms. HYDE. You know, I don't have that information in front of me——

Mrs. BLACKBURN. Would you submit that to us?

Ms. HYDE [continuing]. But I can get it to you, certainly.

Mrs. BLACKBURN. OK. I think that would be great because if you are looking at a 168 million impact to your budget, then I think that all of these conferences and the programs would be something that we would want to look at very closely.

One of the hour-and-a-half long workshops from the October 13, 2012, session is titled "Unleash the Beast: Primal Movement Workshop." It is described in this brochure right here as follows: "Unleash the Beast is a mind/body fitness program that looks to the animals of the jungle for wisdom and skills that can benefit our lives in a myriad of ways. Through the animal-inspired movements, behaviors, and expressions, participants are encouraged to shed layers of formal conditioning in order to return to their primal nature." So is it true that SAMHSA provided funding for this?

Ms. HYDE. As I indicated, we provide funding for the conference. That is correct.

Mrs. BLACKBURN. OK. Are you able to provide us—did you attend this workshop?

Ms. HYDE. No, ma'am.

Mrs. BLACKBURN. You did not? OK. Can you give me any idea of specific examples of such animal-inspired movements, behaviors, and expressions and discuss what studies where evidence has shown them to be effective in treating mental illness and humans?

Ms. HYDE. As I said, I didn't go to that conference or that particular workshop. I can tell you that things like meditation, yoga, other kinds of movement is appropriate for——

Mrs. BLACKBURN. So that is animal movement?

Ms. HYDE [continuing]. Developing stress—for releasing and developing and——

Mrs. BLACKBURN. That would be animal—let me move on.

Ms. HYDE [continuing]. To manage stress.

Mrs. BLACKBURN. When did you begin sponsoring the Alternatives Conference?

Ms. HYDE. I don't remember the first year. We can find out for you.

Mrs. BLACKBURN. OK. We would like to know that and I think, you know, one of your exhibitors here, Mind Freedom International is one of the groups that had a table there. They encourage people to come off their meds, and I think we would be concerned about that.

I also want to know how much money you have spent since the inception of this Alternatives Conference and in conferences in general? Let us help you with this budget gap that you have, and this may be a way to find out. Would you please submit that to us?

Ms. HYDE. I am sorry. Can you clarify what you would like to see?

Mrs. BLACKBURN. Money, how much have you spent on the Alternatives Conference and how much do you spend on conferences in total? And do you pay speakers' fees and travel? Is that covered out of what you are paying?

Ms. HYDE. Congresswoman, it depends on the conference what we pay for. We have reduced our conference support significantly——

Mrs. BLACKBURN. OK. What about scholarships to the conference? Does SAMHSA cover scholarships to the Alternatives Conference?

Ms. HYDE. We do sometimes provide——

Mrs. BLACKBURN. OK. Could you submit that amount to us?

Ms. HYDE [continuing]. Scholarships to this and to other conferences.

Mrs. BLACKBURN. OK. And I would assume they are going to the Unleash the Beast Primal Movement Workshop on taxpayer funds.

March/April 2011 SAMHSA newsletter highlighted the Agency's use of art to raise awareness around behavioral health. Specifically, an award-winning artist, Sam English, was commissioned for $22,500 to create a painting because of his familiarity with prevention and recovery populations. What value—I want you to tell—what value do the American people obtain from SAMHSA's funding of a piece of artwork such as this?

Ms. HYDE. We have a responsibility, Congresswoman, to get the word out about behavioral health to all kinds of populations. In this case, the tribal populations are very clear that the way to do that is to use people from their tribes and nations. This was a tribal——

Mrs. BLACKBURN. $22,500 for a piece of art?

Ms. HYDE. That number is not correct, but this tribal leader is actually a person in recovery and has produced documents and opportunities in the past for other substance abuse programs.

Mrs. BLACKBURN. Please submit the correct number.

And I yield back my time.

Mr. MURPHY. Thank you. The gentlelady's time expired. I now go to the gentlelady from California, Ms. Castor, for 5 minutes.

Ms. CASTOR. Thank you, Mr. Chairman.

I would like to focus your attention on mental health care for children and teens, particularly in schools because what I have heard from so many of my school districts at home and the teachers and parents there is that the schools are a terrific place to identify the emerging issues for the child's mental health or it is the teacher on the front line that understands very well the emotional health of that child day in and day out and that, you know, many schools are able to maybe have a guidance counselor or a school psychologist, maybe just part-time, and they get identified. But there seems to be a real lack of resources available for the true treatment and counseling that that student needs. So many of the parents I hear from, they don't have health insurance or they have a policy that does not provide it. That is going to get better under Mental Health Parity and the Affordable Care Act.

But I still think that what I am hearing from back home is the schools would have the capacity to do more with having psychiatrists and some counselors available. In your testimony—and I understand SAMHSA has some oversight or has oversight of the Safe Schools and Healthy Students Initiative and also Children's Mental Health Initiative. What I have heard from folks back home is while they value those dollars, it is just a drop in the bucket and that resources that were available in the past just aren't there anymore. Could you speak to that and give us a summary of the Safe Schools and Healthy Students Initiative and Children's Mental Health Initiative?

Ms. HYDE. That is correct. The Safe Schools, Healthy Students is a very effective program that we have worked with the Department of Education and the Department of Justice on over the years. It brings together communities, parents, schools, and others to make sure that young people are safe. The program has resulted in great outcomes. We have seen less violence, more perception of safety, more referrals by about 500 percent, more referrals to behavioral health treatment, so as people are able to identify young people in need. So it is a very effective program.

The President has proposed to build on that program in the fiscal year 2014 budget by Project Aware, which would not only expand Safe Schools, Healthy Students statewide in some States, but also add a mental health first aid to help teachers and parents, first responders, and others identified mental health issues early.

Ms. CASTOR. But what is your feeling on or what is your understanding about the needs? As I mentioned earlier in my opening statement, the needs are far outstripping the resources that are available at the local level, state level, and federal level? Or is it a fact that policymakers simply haven't made mental health services a priority and haven't provided the investment that is necessary?

Ms. HYDE. That is absolutely correct. There is not enough. I started out in my testimony, as you may remember, with saying that only about 6 percent of health care spending is mental health, and that is far below what the need is. The President has proposed additional dollars to do additional workforce and has also proposed additional dollars to try to implement the efforts that we have. We also know that the Affordable Care Act will add a lot more coverage for this, but the workforce needs to grow to meet that need.

Ms. CASTOR. How do you collaborate with the Department of Education? Outside of Safe Schools, Healthy Students, what is your understanding of what the Department of Education is able to provide when it comes to mental health care to our schools?

Ms. HYDE. They actually provide a lot of in-school programs, so they support, as does HRSA and other school-based health clinics and others. We provide assistance in the community with the referrals and the connections in the community-based programs. We work with them to provide the materials when they need it for evidence-based practices, and we work to provide training for teachers and others——

Ms. CASTOR. Does that include the IDEA, Individuals with Disabilities Education Act?

Ms. HYDE. In some cases, yes, but we are focusing on not just individuals with identified needs but individuals who haven't yet been identified. We also provide in-school training for teachers to try to help manage behaviors in the classroom.

Ms. CASTOR. Do you really believe when you look at the needs all across America when it comes to mental health for our young people that we are even with all of these initiatives we are really being effective? I mean how do we increase capacity to serve children and need to really be effective and integrated in the school-based setting?

Ms. HYDE. Well, I think we need more programs like Safe Schools, Healthy Students, and more like Project Aware that the President is proposing. The fact is we just have a significant undercommitment to mental health and mental illness treatment and recovery in our country and we need more of that. The Affordable Care Act will help with that but only as we continue to build up the workforce to be able to meet those needs.

Ms. CASTOR. Thank you very much.

Mr. MURPHY. Thank you. I now recognize Mr. Olson from Texas for 5 minutes.

Mr. OLSON. I thank the chair and thank him for holding this very important hearing.

America's mental health problems that lead to violence may lose control every day in America. The violence doesn't just happen at Virginia Tech; it doesn't happen in a parking lot in the Safeway in Tucson, Arizona; it doesn't just happen in a movie theater in Aurora, Colorado, or at a school in Newtown, Connecticut. They happen 1.5 miles from my hometown, my home, my hometown of Sugarland, Texas.

At about 9:00 p.m. on Sunday, April 7, of this year, a 31-year-old constituent hit the wall. He had been sick for about 13 years and was in the process of moving back home with his parents. He had been seeking painkillers from doctors but his doctors did not give him the drugs. He became angry with his parents and threatened them with a hatchet and a rock. Terrified, they fled their own home and called 911. The Sugarland police showed up. The son was barricaded in his parents' house.

Eventually, he emerged with a rifle, and when he pointed it at the Sugarland police, he was shot and killed in his front yard. His parents heard the gunshots that killed their son. And we can never accept what happened in my hometown of Sugarland, Texas.

Administrator Hyde, I know that SAMHSA is a small agency. You have an important role to play. You mentioned earlier this year in your testimony before the House Appropriations Committee on children's mental health on March 20 that the President has directed his Secretaries of Health and Human Services and Education to foster a national dialogue on mental health. What if it all is SAMHSA's role in this dialogue being coordinated with the $130 million in new SAMHSA-led programs that the President announced on January 16 of 2013? Basically, how is that money being used in this new initiative?

Ms. HYDE. Congressman, that money that is being proposed is for fiscal year 2014 so we don't have those funding—that funding yet. It would require Congress to act for us to have it.

The description of the incident that you described is a huge tragedy. These are not things that we want to happen. We have models out there of mental health and crisis intervention working with police and we have been working a lot with police and sheriffs association. We don't have a program specifically around crisis intervention. I wish we did. It is something we know that we can do better about but we don't have the funding to do. States use some of their block grant funds for these dollars but they don't stretch nearly far enough.

So this is an area where we have some evidence-based practice and we don't have the resources to put it into place all over the country as we should.

Mr. OLSON. Thank you, ma'am. I will have some questions for the record but I yield the balance of my time to my colleague from Texas, Mr. Burgess.

Mr. BURGESS. I thank the gentleman from Texas for yielding.

I just had a follow-up question on what Mr. Butterfield was pursuing on to the effects of the sequester. I mean we hear a lot about that in this committee and I just have to tell you I am struck by the fact that it seems that nowhere in the federal agencies is anyone responsible for the prudent management of taxpayer money. In private business when you are struck with a budget reduction, which happens and certainly happened to me when I ran my practice, the first thing I did was not sacrifice customer service or sacrifice activities that were central to the core mission of my business.

And yet, we hear it time and time and time again from the CDC, from HHS, now from your agency that because of the sequester you can't perform the functions of your core mission, and yet there are ancillary activities that are occurring that consume large amounts of dollars. I mean it is basic Six Sigma management. You do your core mission first and everything else is secondary to that. And, you know, we hear stories over and over again about incompetence of the federal agencies. I would just urge you to be certain that your number one mission needs to be fulfilled and everything else comes secondary.

I thank the gentleman for yielding and I will yield back.

Mr. MURPHY. I now recognize Mr. Green for 5 minutes.

Mr. GREEN. Thank you, Mr. Chairman. Administrator, welcome. I guess because you have a lot of Texans on the committee, you got my neighbor and Dr. Burgess of North Texas. I have a district in Houston, and previously, my colleague Ranking Member DeGette touched on a criticism from our second panel on your agency, and I would like to pursue that a little bit more.

Dr. Torrey claims that incarceration of mentally ill people in jails in your presence is not a priority for SAMHSA. One, is this true? And are incarcerated mentally ill people not your priority? What agency do you work with that addresses the concern of this particular population?

Ms. HYDE. Thank you for the question. We do have criminal justice programs in our budget. We do a lot of work with Sheriffs Associations, with jail and corrections practitioners. We have done a significant amount of work with juvenile justice and interfaced with the Department of Justice on that.

The dollars appropriated for these activities are fairly small compared to some of the other dollars we have, but to the limits of our Appropriations, we have done a lot of work in the criminal justice area both with substance abuse and mental health.

Mr. GREEN. I appreciate it. And, well, if you could get me anything that you have worked on in Texas so I could see it. In an earlier life I did mental health as an attorney representing folks and I have worked with our sheriff. I watched last year as they were trying to divert people in Houston Harris County from, you know, being incarcerated and literally walk them two blocks to a federally qualified health clinic that also sets up an appointment, get them on their meds, looks for housing, and things like that. So we don't provide most of that funding. It comes locally, I guess, but it would be good if we could just provide resources to particularly in urban areas but I know rural areas have the same problem.

Dr. Satel, another panelist, alleges that SAMHSA's guiding philosophy of care is the recovery model and its tears policy away from the needs of those living with serious mental illnesses. Administrator, can you describe the recovery model and your views on whether it is an adequate guiding principle for the Agency?

Ms. HYDE. Thank you, Congressman. The recovery is important. It is part of what we are about. We do want people to recover. I think there is an assumption that recovery means not getting treatment. That is not true. Recovery includes getting the kind of treatment and services a person needs to maintain their symptoms as well as their lives.

We separate recovery into four areas: the treatment or health area; as well as housing to make sure that people don't end up homeless; and to make sure that they have the social networks they need to survive in the community; and then that they have the jobs or the education that they need to make a living. So we support all of those in the recovery effort

Mr. GREEN. Well, and I understand recovery is important but, you know, I consider mental illness something you manage, too. And, you know, sometimes I am not going to recover from a heart condition. I may manage my illness and I would hope that is part of your recovery method, being able to manage that illness because that was our problem of getting people to realize their illness and you can manage it and function to sometimes a higher level instead of being able to recover from your particular mental illness issue.

One of the issues that came up and Dr. Burgess touched on it that Dr. Torrey claims your agency spent 22,000 on commissioning artwork to hang in your offices, and I hope that was before sequester and it was something you couldn't get out of, but that is what Members of Congress and O&I Committees are looking at. And can you explain that expenditure?

Ms. HYDE. You know, Dr. Torrey and I have known each other for a long, long time. He claims many things, not always that I agree with. We have an obligation to try to do public awareness and support. One of the things that we did is some special approach to try to get information out to tribal communities. We used a person in recovery from substance abuse and mental illness who has provided other efforts and other art for posters which we produced. We produce posters for a lot of places in a lot of ways, and the combination of those efforts was what you are referring to. The dollar amount is not correct but we will be glad, as requested, to provide that to you later.

Mr. GREEN. OK. Mr. Chairman, thank you.

Ms. DEGETTE. Would the gentleman yield?

Mr. GREEN. I would be glad to yield my last 2 seconds.

Ms. DEGETTE. And when did the Agency purchase that artwork?

Ms. HYDE. It was a couple of years ago.

Ms. DEGETTE. So it was before sequester took place?

Ms. HYDE. Absolutely, yes.

Ms. DEGETTE. And I am going to back up what Mr. Green was saying and say I am hoping that those kinds of expenditures aren't being made right now with sequester and other cuts looming.

Ms. HYDE. I think it is fair to say that we have had to cut a lot of our public awareness efforts, yes.

Ms. DEGETTE. Including things like that?

Ms. HYDE. Including things like that.

Ms. DEGETTE. Thank you. Thank you. I yield back.

Mr. MURPHY. Thank you. The gentleman's time has expired. I now recognize the gentleman from Virginia, Mr. Griffith, for 5 minutes.

Mr. GRIFFITH. Thank you, Mr. Chairman. Thank you for being here today. Appreciate it.

There is substantial evidence that court-ordered assisted outpatient treatment can reduce hospitalization and length of stay, increasing the receipt of psychotropic medications in intensive case management services, among other improved policy-relevant outcomes. Does SAMHSA provide financial support to organizations that oppose efforts to expand court-ordered outpatient treatment programs nationwide?

Ms. HYDE. Again, we provide resources to organizations that may have positions that are not consistent or that we don't necessarily espouse one way or another. So I can't really answer that question. My guess is that there are probably some of the organizations that receive some dollars and don't appreciate that approach.

Mr. GRIFFITH. Because there appears to be some data that some SAMHSA-supported statewide programs such as the Pennsylvania

Mental Health Consumers Association and the California Network of Mental Health Clinics actively lobby against proposed expansion of assisted outpatient treatment in their home States. And I have to wonder while supporting prominent skeptics of assisted outpatient treatment, have you all launched or do you have any plans to launch an assisted outpatient pilot program to maybe encourage folks to be in favor of these types of programs?

Ms. HYDE. I am sorry. Let me comment first that no one using our dollars has the right to use federal dollars for lobbying. So to the extent there is an organization that we find that is doing something of that nature, they should be either using other dollars or not doing it. So——

Mr. GRIFFITH. Yes, ma'am.

Ms. HYDE [continuing]. We don't support that. On the assisted outpatient treatment, the research that has been shown for assisted outpatient treatment to be effective also is very clear that it is the treatment and service that is effective. So to the extent that, for example, in New York where there was a major assisted outpatient treatment program and an evaluation of that program that was extensive, there were also a lot of new dollars poured into that system to make it work. So to the extent that the services are there, then assisted outpatient treatment may be effective for some individuals.

Mr. GRIFFITH. And you certainly don't oppose in those cases where it is necessary involuntary treatment?

Ms. HYDE. We do not oppose any kind of treatment that is effective, absolutely not.

Mr. GRIFFITH. OK. And you don't have any problem with having those folks then put on a list to not be able to purchase firearms?

Ms. HYDE. I don't have an objection to that. I do have objection to some of the language that is in the law about that, but I think everybody is working on that. We are looking at it, things like mental defective and things of that nature don't make a lot of sense today, so we do need to revise that law in some ways.

Mr. GRIFFITH. Well, we certainly need to make sure that those who have severe mental illnesses with a tendency or either the individual has a history or the diagnostic area, that those folks are put on a list so that they can't purchase firearms lawfully. Wouldn't you agree with that?

Ms. HYDE. I think our department is working with the Department of Justice on the language around that law, yes.

Mr. GRIFFITH. All right. And if I can be of any assistance on that, please don't hesitate to contact me because we have serious concern. I represent the 9th District of Virginia and the Virginia law had to be changed when I was in the state legislature because we let Mr. Cho slip through the cracks. And he had been told by a court to go get help but nobody ever made sure he got that help. And we had to make sure that we changed the law because not only did he not get the help but that he was never placed on the list of folks who weren't able to buy guns. And so after he was court-ordered to get the help, he went out and purchased firearms and he wasn't on anybody's list as a no. So we had to change that law.

I would be happy to help in any way that we can on that. And in regard to the folks that were doing some lobbying, I know they are not supposed to and certainly not supposed to use SAMHSA funds for that, but I have read some reports that indicate that might be happening, and one of the suggestions is that Congress could consider giving you all more authority to regulate those individuals and to regulate patient advocates both on lobbying and other issues. Would you welcome that additional responsibility?

Ms. HYDE. Mr. Congressman, if you have any information that suggests someone is using our dollars to lobby, please let us know. We will take a look and we will exercise whatever authority you give us to do the right thing.

Mr. GRIFFITH. All right. I appreciate that as well. These are very serious issues. I do note that when you were talking about funding, maybe we need to do something because I noticed in your written report that you are doing some kind of a study that indicates folks are using less tobacco, particularly in your youth programs. And while I certainly don't advocate that young people be involved in the use of tobacco and recognize that that is a substance, when we are dealing with serious mental illness versus tobacco use, I would rather put the money on serious mental illness. Do we need to put that into the language of your appropriations or is that something that you have the power to do?

Ms. HYDE. Well, once again, 70 percent, give or take, of our dollars are about substance abuse, and tobacco use, especially among young people, is a substance of abuse and addiction does cause health issues. About half the deaths——

Mr. GRIFFITH. Can you give me the dollar amounts that you all use on your tobacco programs?

Ms. HYDE. On tobacco?

Sure.

Mr. GRIFFITH. I would appreciate that. And with that, Mr. Chairman, I see that my time is up and I yield back.

Mr. MURPHY. Thank you. The gentleman from Missouri is now recognized, Mr. Long, for 5 minutes.

Mr. LONG. Thank you, Mr. Chairman.

Thank you, Mr. Chairman. And in full disclosure, Ms. Hyde, I think it is important that we state for the record that you and I both lived in Springfield, Missouri, for a while. Is that correct?

Ms. HYDE. That is correct. I grew up there.

Mr. LONG. So did I so welcome to the Committee. Glad to have you here.

You mentioned earlier that sequestration had cost SAMHSA I believe $168 million out of the budget?

Ms. HYDE. That is correct.

Mr. LONG. And that is a budget of what size?

Ms. HYDE. It is about $3.2 million, 3.3. It depends on the year. It depends on where—before or after sequester. It is about $3.4 million, all sources.

Mr. LONG. OK. Growing up in Springfield, Missouri, you are familiar with——

Ms. HYDE. I am sorry. I am sorry. Excuse me, 4 billion. It is about $4 billion.

Mr. LONG. Four billion for SAMHSA?

Ms. HYDE. About $3.4 billion altogether, but remember about 70 percent of that is substance abuse.

Mr. LONG. Is what?

Ms. HYDE. Is for substance abuse.

Mr. LONG. Substance abuse. There is been a lot of talk about sequestration today and you are familiar with Springfield, Missouri, growing up there as I did. And at the corner of Glenstone and Battlefield, the Barnes & Noble there you could find myself and my wife and our daughters in there about 3 nights a week. And I read a lot. And especially in this occupation we fly out here on Monday and fly home on Friday, you read a lot. And I am kind of old-fashioned. I don't read the I whatever Kindles and I-books and things like that. I like the pages in my hand and all of that. I don't know why but I just like that.

And so one book that I bought was Bob Woodward of Watergate fame. He wrote a book last year. It came out September 11, same day that our consulate was attacked in Benghazi. But anyway, I can get a picture of it on my iPad. I can't read it on my iPad that I can get a picture of the book, "The Price of Politics." And that is pretty good for me, wasn't it?

So I probably bought it on September 12, because I was anxious to get the book because it was kind of my first 2 years up here and what went on in Congress and all of the budget battles we had where we spent 42 percent more than we take in every day in this town. And no one, as you know in Springfield, Missouri, where you grew up, where I grew up, you can spend 42 percent more than they take in.

So the book I was anxious because I knew it was going to walk us through the process and when Speaker Boehner would talk to the President and Eric Cantor would be involved in back-and-forth and everything.

So I got a hold of the book, read it, and then I happened to run into—I was watching Morning Joe one morning and then I saw Bob Woodward on there being interviewed about a different topic, and then, as fate would have it, I am walking across the Hill here and get to a stop sign on a corner and there stands Bob Woodward, still has his makeup on from Morning Joe. And I went up to Mr. Woodward and I said, Mr. Woodward, I have got to tell you. I said I just read your book "The Price of Politics" and loved it. I said I am going to say something to you—and this is like in November/December last year—and I said I don't know about the meetings that I wasn't in, but the meetings that I was in I said it was like you had a tape recorder in the room. That is how accurate your reporting was. He said, well, thank you. Thank you very much. And in that book where we can only assume, I think, that if the reporting was accurate in the meetings I was in that you would be safe to assume that the reporting was accurate in the meetings I was not in.

And I believe—I am not sure but I think it is on page 326 but I don't know how to read a book on my iPad—but I think it is on page 326 talks about where sequestration came from. Do you know where it came from, whose idea it was?

Ms. HYDE. Congressman, I think these are issues that are going on between you and the White House and others and I think that you should take those questions and comments to them.

Mr. LONG. Well, I think that you have used sequestration of a lot here today and 168 million out of your budget, and, you know, according to Mr. Woodward who was accurate in the meetings that I was in, it came from the White House. It came from the President, sequestration. And now that it has gone into effect, we have a lot of different agencies coming to us on a lot of different issues and so I just want to point out for the record where sequestration came from so that when we are talking about it in hearings like this, and we may talk about it later in the second panel today, I just thought that was important to bring out. And I yield back.

Ms. HYDE. Yes, Mr. Congressman, I think sequestration came from a number of different drivers and I think it is very clear that Congress had the authority to make a decision that it would not go into effect. I think everybody wanted it not to go into effect. I think everybody assumed to that there would be another——

Mr. LONG. Isn't that kind of—well, I am not going to get into a discussion with you and I am controlling the time, but I think it is kind of bad to come up with a law that you are going to pass thinking it won't go into. And I yield my time back to the chairman.

Mr. MURPHY. The gentleman yields back. His time is expired. And I now recognize the gentleman from Georgia, Dr. Gingrey, for 5 minutes.

Mr. GINGREY. Mr. Chairman, thank you very much. Administrator Hyde, can you understand the criticism leveled by some against SAMHSA that the Agency's focus on behavioral health being such a broad and amorphous category has come at the expense of prioritizing resources for treating those with serious mental illness?

Ms. HYDE. No, I don't agree with that. And again, behavioral health is a broad term that we use for both substance abuse and mental health and mental illness. It is about prevention, treatment, and recovery. So it is a broad term. Our budget is about 70 percent substance abuse. The other part of our budget is about 75 to 80 percent about serious mental illness and serious emotional disturbance. So no, I don't understand the criticism.

Mr. GINGREY. Well, in other words, look, to me it has drawn attention away from the biological basis behind the most serious of these illnesses focusing instead on environmentally driven behaviors. One example of this is something called Leading Change, SAMHSA's plan of action for 2011 through 2014. In this document of over 100 pages setting out the Agency's eight core strategic initiatives for the coming years, the word of schizophrenia or bipolar disorder do not appear at all. Are these conditions not defined by both the National Institute of Mental Health and SAMHSA as examples of SMI, serious mental illnesses?

Ms. HYDE. As I said earlier, the Leading Change document doesn't have any diagnoses in it. It is not the purpose of that document. The definition of serious mental illness is different in different places. Congress has given us a definition in one place that is different with the NIMH in another place. We have—each State makes their own definition of it for purposes of the block grant, so there is lots of different definitions, and certainly, people with schizophrenia and people with bipolar disorder are some of the diagnostic categories that could be a person with serious mental illness. In many cases, it also includes a function or a history that makes the individual in need of intensive treatment.

Mr. GINGREY. Well, there is a lot of controversy. I read an article this weekend in the Wall Street Journal that expanded there was a lot of coverage of mental illness. Those of you may be here on the panel or members of the subcommittee may have read these articles about DSM–V and the concern, you know, about how in the world, you know, psychiatrists and psychologists getting away from really the cause of some of these serious things and just throwing medication at it. Maybe that is another subject, maybe not.

But according to the National Institute of Health, schizophrenia affects around 2.5 million Americans while bipolar disorder affects 5.7 million Americans in this country. And I am discouraged that it seems to me, Madam Administrator, it just seems to me that your action plan fails to address both of these populations of people. In the time remaining, can you please explain to this committee what if anything SAMHSA has done in the last 5 years which has impacted treatment for a patient with one of these diseases if they walk into a typical community mental health center in an average State, Georgia, mine; what is it, Missouri? Yours and my friend Mr. Long in front of me. What happens if a person walks into these community mental health centers in the average State in this country, Missouri or Georgia?

Ms. HYDE. We know health centers across the country frequently are funded by the Mental Health Block Grant, which SAMHSA administers. They frequently are recipients of SAMHSA grants. Almost all of them now get Medicaid dollars and Medicare dollars. Most of them now get private insurance dollars as well. So as we indicated earlier, ⅔ of the money to fund those services come from Medicaid, Medicare, and private insurance.

The SAMHSA grant that we provide help those community mental health centers to provide those things that a typical insurance benefit would not necessarily provide. We provide it for both a different kind of set of services, evidence-based practices that are over and above those, and we also provide it for those individuals who were not covered the moment.

So there is a lot of ways in which if you walk into a community mental health center, you can bet they are touched by SAMHSA funding and they certainly may very well be touched as well by SAMHSA technical assistance, by their training, by our public education and outreach and awareness. They may use our data. There is a number of ways in which those community health centers are touched by us.

Mr. GINGREY. Madam Administrator, that is helpful. Thank you and I yield back.

Mr. MURPHY. Thank you. I now recognize the gentleman from Iowa, Mr. Braley, for 5 minutes.

Mr. BRALEY. I want to talk about the Garrett Lee Smith Suicide Prevention Program, a program that is very personal to me because I lost my niece to suicide her senior year of high school, and I am concerned about the proliferation of social media sites and the amount of information available to teenagers who are contemplating suicide and who have some of their concerns reinforced about information provided by those sites. What are we doing to monitor the traffic on Facebook and Twitter and other social media sites to be more aggressive in intervening with young people to prevent them from taking this most drastic step to end their problems?

Ms. HYDE. It is a great question. We have a relationship with Google, who actually has allowed us to have our National Suicide Prevention Hotline be the first thing that comes up. You know, normally, Google will just do a—it will come up different every time, but if you Google suicide, it will come up our lifeline number first.

We also have relationships with Facebook who worked with us over the release last year of the National Strategy for Suicide Prevention, which was the Surgeon General's report that was developed by a public-private partnership that we participated heavily in. Facebook is one of the partners there and they have actually—now are monitoring some of the language and some of the materials or some of the chatter that is going on and trying then to intervene and allow that individual to know that there is a way that can reach out. So we have good public-private partnerships working with entities like that to try to address some of the issues you have raised.

Mr. BRALEY. What are we doing to affirmatively promote information through those platforms to try to counter some of the misinformation and encouragement that takes place over those platforms and educate young people to the alternatives that are available to seek help when they are in such a time of crisis in their lives?

Ms. HYDE. Again, I think there is a couple of ways. We have a Garrett Lee Smith, as you know, program that is campus-based. That is one of the age groups that has a high proportion of death by suicide and a high proportion of individuals who either seriously consider or act on those issues. Those grants help to raise awareness. They help to provide support groups. They help to provide actually information to faculty and students. So we have a fairly extensive—again, limited by the dollars that we have, we have a fairly extensive effort around that.

We also do a significant amount of public awareness and support with materials, posters, things to hand out to people. I have got them in my backpack. I carry them around, signs of suicide prevention that you can give to anyone who appears to be talking about that kind of thing. We have also tried to provide some training for parents and survivors of actual attempts as well as parents of—or family members of those who have experienced this. So we do a fair amount of work in that and we do it with partners. It is not just SAMHSA. It is some of our stakeholder partners who work on this issue extensively.

Mr. BRALEY. Thank you. That is all I have.

Mr. GRIFFITH [presiding]. I now recognize the gentlelady from North Carolina, Mrs. Ellmers.

Mrs. ELLMERS. Sorry. Thank you, Mr. Chairman. Thank you, Ms. Hyde, for being with us today. You know, mental health in this country is so important and certainly one of the issues that Oversight and Investigation is taking on with a great passion. We know that the health care system in this country needs to be reformed. We know that the mental health system in this country needs to be improved upon.

And that brings me to my concerns about the way that your organization is moving forward with hard-earned taxpayer dollars. I am concerned that there seems to be a lack of physicians and nurses and social workers that are a part of your organization, and I have reviewed all of the information here, and I would like to hit on a couple of very specific issues, especially with healthcare professionals. I read the brochure on the Alternatives Conference that you are a part of, and I don't see anywhere where they discuss continuing education credits for psychiatrists, for psychologists, for nurses, for social workers. Is this correct? I mean is there no program that you are associated with with at least education and training for these healthcare professionals?

Ms. HYDE. No, that is not correct. Alternatives is just one thing that we do. We also work with—I gave a keynote at the American psychiatric nurses Association as well. So there is lots of different efforts that we do with psychology groups, social work groups, nursing groups and others to try to——

Mrs. ELLMERS. But not for this particular conference that you do like, again, providing accredited hours of education training for these individuals?

Ms. HYDE. Not at—I don't believe that is——

Mrs. ELLMERS. Through federal dollars?

Ms. HYDE. I would have to check that for you.

Mrs. ELLMERS. OK. And if you could provide to our committee those keynote points that you made at that particular conference, that would be helpful as well.

Also, some of the other issues, and there again we are looking at federal dollars that are being spent here. We discussed the sequester cuts that you have identified as problematic, and I can certainly understand that as well. However, I think there are dollars that are being spent here that aren't necessarily getting to the root of the mental health issues that we are faced with in this country, especially with young people.

But also in the document that you have, Leading Change, you do make very specific reference to suicide, substance abuse, which obviously definitely falls under your jurisdiction, depression, PTSD, so you are able to name specific diagnoses. So this is something that you do not have any difficulty talking about specific diagnoses, is that correct?

Ms. HYDE. In the right context, absolutely not. We don't have any problem with that in the——

Mrs. ELLMERS. OK. So that is a yes. In your document Leading Change again, you do not specifically mention schizophrenia, bipolar disorder. So is that something that you do not regard as serious mental illness?

Ms. HYDE. Of course we consider those serious mental illness diagnoses. That document was not a clinically-based document. It laid out our eight strategic initiatives ranging from prevention to military families to trauma issues to quality issues to public awareness and support and to electronic health records.

Mrs. ELLMERS. OK, well——

Ms. HYDE. The nature of that document——

Mrs. ELLMERS [continuing]. I would like to hit on one specific area, though, in relation to those with my 1 minute that I have left. One of the areas there again getting back to that document, getting back to schizophrenia and bipolar, do you believe medication is a proven evidence-based treatment for these diagnoses?

Ms. HYDE. Absolutely. For most people. There are, however, a number of people who have those diagnoses for which medication is still not effective.

Mrs. ELLMERS. Well, see, that is one of those curious areas there because you also are providing funding to organizations that support and promote taking away medical treatment. Do you acknowledge that?

Ms. HYDE. We provide funding for entities to do the grants that we give them to do. Whether or not they espouse other——

Mrs. ELLMERS. Well, then, what are the criteria that you would give a grant if it isn't a treatment that you would support for mental illness——

Ms. HYDE. The——

Mrs. ELLMERS. Ten seconds.

Ms. HYDE. It depends on what the grant is. There is a lot of different grants that we give for a lot of different purposes. I would be glad to talk to you offline about that some more.

Mrs. ELLMERS. Well, I would like to see that criteria of how you qualify an organization that you are giving hard-earned taxpayer dollars when it is something as serious as mental health. And if you could provide the criteria or the application process that would be wonderful so that we can see who gets this money and how you qualify them. Thank you very much. I went over and I apologize, Mr. Chairman.

Mr. GRIFFITH. I now recognize the gentleman from California, Mr. Waxman, for 5 minutes.

Mr. WAXMAN. Thank you, Mr. Chairman.

I understand there has been a good deal of discussion regarding the role of Protection and Advocacy Program, and I am very familiar with this program having worked on the authorizing statute when I was chairman of the Health and Environment Subcommittee. The Protection and Advocacy for Individuals with Mental Illness Act authorized Protection and Advocacy organizations to, one, protect and advocate for the rights of people with mental illness; and two, investigate reports of abuse and neglect in facilities that provide care or treat people with mental illness.

I know we have heard criticisms about efforts of these entities in specific cases, but I want to underscore two points: First, Protection and Advocacy organizations are designed by their respective States and are acting within the scope of congressionally mandated activities; and second, absent their efforts, thousands of individuals would continue to experience abuse, neglect, and violation of their civil rights.

For example, in 2011 the PAIMI program supported casework for approximately 4,000 children and adolescents, nearly 13,000 adults and elderly individuals, and entities receiving funding resolved over 11,000 complaints. Now, Administrator Hyde, you also noted that SAMHSA is developing a framework to guide behavioral health services and programs throughout the country and to provide a consistent set of measures for use by various stakeholders. Can you tell us how you expect this framework to improve accountability for your stakeholders?

Ms. HYDE. Thank you. Yes, we are developing a National Behavioral Health Quality Framework. It is modeled on the National Quality Strategy that was required by Congress so we have been working with the organizations to develop that. It has six goals, things like safe care, evidence-based care, effective care, patient-centered care, et cetera. And we are developing rules and measures with the National Quality Forum and others to populate what that quality framework might look like.

Mr. WAXMAN. Is there anything else you would like to add with regard to SAMHSA's ongoing accountability efforts?

Ms. HYDE. Yes, thanks for the question. We—every one of our programs—our grant programs we evaluate. We have evaluation data. We have one of the highest number of the GPRA, what we call GPRA or government accountability measures of any of the agencies. We report that data. We make it available. All of our grantees are doing that. We also work hard—we are in the process of revising our data reporting and data collection activities both for our discretionary grants, as well as for our block grants to assure that we have the best data possible available for you all, as well as for the public. So we do a lot of work in this area. We also do oversight of each of our grants and then we respond to complaints and investigations and investigate those when they are brought to our attention.

Mr. WAXMAN. And even as you are requesting more information from your grantees, I understand there are instances in which you lack the authority to require States and other grantees to report on certain measures, for example, within the Community Mental Health Services Block Grant. Is that correct?

Ms. HYDE. Well, the block grant is meant to be a flexible funding stream, so for States—they make different choices about that. They do provide us information about how they use those dollars and we do report those back. We also—but we—so we have limited authority in some ways but I think it was designed to be a flexible funding stream for each State.

Mr. WAXMAN. Well, it is a flexible funding stream for each State but when you try to get information from them and you are asking them to report on certain measures, are you able to get the information you need?

Ms. HYDE. To an extent we are and we have just begun a new effort with the States to try to see how we can collectively report data better. We all want to improve that so we have data now. We have information about what the States use the dollars for——

Mr. WAXMAN. Yes.

Ms. HYDE [continuing]. But we do want to improve those data. We are always looking for ways to improve that accountability for Congress and the public.

Mr. WAXMAN. I think we can agree that it is important to make sure there are clear reporting requirements and consistent measures in place so that we can track progress over time. I hope that we can work together to support SAMHSA's efforts on this issue.

And I thank the chair for recognizing me. I yield back the balance of my time.

Mr. MURPHY. I thank the gentleman. I now recognize the gentleman from Ohio, Mr. Johnson, for 5 minutes.

Mr. JOHNSON. Thank you, Mr. Chairman. And I appreciate the opportunity. Thank you, Ms. Hyde, for being here today.

I do have one comment I want to make, though, before I get into the questions because I was struck by what my colleague from Missouri mentioned about the idea of sequestration because that seems to be a hot topic today. We consistently have administration officials come before our committees to talk about sequestration and the fact that it is hurting their ability to do the job that they are assigned to do. However, we know and it has even been admitted that the idea of sequestration came from the White House.

I came from the floor just a little bit earlier where our minority whip talked about or tried to make the case that once again this was a Republican House idea, which it was not, and that we have abdicated our leadership because we haven't worked across the aisle to try and replace the sequestration when in fact we passed two pieces of legislation in the last Congress that would replace sequestration, give the Administration the flexibility that it needed by making more responsible spending cuts.

So I am a little frustrated with the disingenuousness that continues to come from the Administration and the agencies that try to blame sequestration on their inability to do their jobs. I wonder where that backlash was when the Administration was putting forth this idea. That is just a comment.

Let me ask you, Ms. Hyde, how our review criteria for SAMHSA's formula and competitive grant programs developed?

Ms. HYDE. Review criteria come from the RFAs, which is request for applications. So when we developed the RFAs based on congressional input and the program design, then we develop criteria from that about what the applicants have to meet. There is a checklist that the reviewers have to go through. They actually have to put the page number of the application of where the different criteria are in the application. They are scored and then that scoring drives the decisions about development. Now, that is sort of the discretionary grants. The formula grants like block grant and the PME program and others, those are done by application from the States because each State is entitled to those dollars so long as their application——

Mr. JOHNSON. How do you ensure that SAMHSA grant reviewers follow the criteria consistently?

Ms. HYDE. As I said, there is a checklist and they have to identify the page number in the application where they actually saw the criteria that they are looking for in the grant review. So there is an extensive documentation about how they reviewed the criteria and how they—the scoring occurs.

Mr. JOHNSON. What kind of oversight does SAMHSA perform over its grantees after the grant is awarded?

Ms. HYDE. Each grantee has a grant project officer. Those grant project officers provide oversight by visits, by audits of papers, by technical assistance, and by looking at the materials that are provided for reporting and overseeing whether or not those are up to snuff and what they are required for meeting their grant performance.

Mr. JOHNSON. How often is this type of oversight performed?

Ms. HYDE. It depends on the situation and depends on how many grantees there are, what kind they are, whether or not they are sort of usual grants or new grants. So new grantees may get additional attention or more oversight than grantees who have been going for a while, et cetera.

Mr. JOHNSON. OK. Ms. Hyde, some have called the annual Alternatives Conference that is funded by SAMHSA to be the largest anti-psychiatry, anti-treatment meeting in the U.S. In your view, what is the value that has been obtained for the American people and more specifically the mentally ill from these conferences?

Ms. HYDE. Again, this is one event of many that we have worked with——

Mr. JOHNSON. But it is paid for by the taxpayers, correct?

Ms. HYDE. It is one event that SAMHSA funds.

Mr. JOHNSON. But it is paid for by the taxpayers, correct?

Ms. HYDE. Well, SAMHSA uses taxpayer dollars——

Mr. JOHNSON. There you go.

Ms. HYDE [continuing]. That is correct.

Mr. JOHNSON. OK.

Ms. HYDE. But it is only one. We have many others. The effort is to provide information and to provide assistance, for example, trying to provide help and information about how people can enroll in coverage to get access to treatment and services. We provide information there on different types of treatments and approaches that will help individuals. We try to develop workforce efforts there. There is a number of opportunities that we do at that conference, as with many of the other conferences that we support.

Mr. JOHNSON. Mr. Chairman, I yield back.

Mr. MURPHY. Thank you. I now recognize Mr. Tonko for 5 minutes.

Ms. DEGETTE. Will the gentleman yield to me just for one question?

Mr. TONKO. I would.

Ms. DEGETTE. Thank you. I just want to ask you quickly, Administrator Hyde, irrespective of whose fault the sequester was—and I don't think it was my fault because I voted no—but irrespective if it is the White House or the Congress' fault, the fact is that the cuts have gone into effect and your agency still has to administer those cuts, correct?

Ms. HYDE. Correct.

Ms. DEGETTE. Thank you. Thank you, Mr. Tonko.

Mr. TONKO. Thank you, Ranking Member DeGette. And thank you, Mr. Chair. Thank you as well to Administrator Hyde for your testimony here today on the sequestration rundown. I think one piece was left out that the Democrats in this House proposed an alternative to sequestration. It was blocked by the majority in the House.

Like many of my colleagues, I, too, am concerned over allegations of wasteful spending and the questionable activities of some

SAMHSA grantees. These incidents should and will continue to receive the utmost scrutiny from this committee and I applaud the chair's initiative to conduct this important oversight hearing.

However, I also have significant concerns that the instincts of some of my colleagues in investigating these allegations would be to throw the proverbial baby out with the bathwater resulting in further damage to our Nation's already reeling mental health system. This is not the right approach.

And according to the National Association of State Mental Health Program Directors, States have cut at least $4.35 billion in public mental health spending from 2009 to 2012. In these tough times, federal funding from sources like SAMHSA's Community Mental Health Sources Block Grant is more important than ever to ensure that even more individuals do not fall through the cracks of our fragmented mental health systems.

Administrator Hyde, that being said, I think the two biggest criticisms lobbied against SAMHSA are its funding of the Consumer and Consumer-Supporter Technical Assistance Centers and the Protection and Advocacy for Individuals with Mental Illness program. Can you tell us what proportion of SAMHSA's mental health budget in 2013 was spent on these very programs respectively?

Ms. HYDE. Congressman, I don't have that number off the top of my head but I can tell you it was miniscule compared to the overall expenditures. We can get that.

Mr. TONKO. Sure.

Ms. HYDE. We can do the math and get you that information.

Mr. TONKO. Well, according to my information, SAMHSA's 2014 budget request document, the Consumer Technical Assistance Centers program was funded at a level of 1.9 million and the Protection and Advocacy for Individuals with Mental Illness program was funded at 36 million. Together, these programs would comprise a little more than 3 percent of SAMHSA's $954 million mental health budget in 2013. If you could check on those numbers, please, Administrator Hyde——

Ms. HYDE. Will do.

Mr. TONKO [continuing]. I would appreciate it and get back to the Committee. And by contrast, what percentages of SAMHSA's mental health funding went directly to States to support mental health treatment services in 2013?

Ms. HYDE. About 48 percent of our mental health dollars went to States through the block grant program. There are additional discretionary grant programs that States have dollars from. Again, we could add up how much of that is States. Most of our dollars do go towards States.

Mr. TONKO. So when you say most, like a rough percentage would be?

Ms. HYDE. Again, I don't know how many of our grantees are States versus communities sitting here, but we can certainly get you that information.

Mr. TONKO. It appears as though a vast majority of the dollars are going toward assistance for treatment. Regardless of how much money is spent on programs such as the Consumer and Consumer-Supporter Technical Assistance Centers and the Protection and Advocacy for Individuals with Mental Illness, these programs should be accountable for spending taxpayer money wisely. I share the opinions of many on this committee that grantees should not be able to use federal funds to lobby against duly enacted state laws. Can you describe what type of internal safeguards SAMHSA has in place to ensure that these monies are spent appropriately?

Ms. HYDE. We review the grantee expenditures to assure that they are being spent on the issues that were identified in their applications and that the funding allows. If we are—if someone brings to us an allegation that those dollars are being spent inappropriately, we investigate that and act accordingly.

Mr. TONKO. Thank you, Administrator Hyde.

In closing, I would just like to point out that many of the programs that we are scrutinizing here today such as the Protection and Advocacy for Individuals with Mental Illness program saw their congressional authorizations expire at the end of 2003. Simply put, as a Congress, we have been derelict in our duty to provide proper and continuous oversight to this agency, and as such, this agency shares in the responsibility for any failures at SAMHSA.

I would strongly urge my colleagues on both sides of the aisle to continue this dialogue and to work to enact meaningful legislation that will provide SAMHSA with the appropriate congressional guidance it needs to find out what works and what doesn't and to ensure it is meeting its core mission of serving individuals with serious mental illness. I stand more than ready to work on this goal with anyone who will join. And with that, Mr. Chair, I yield back.

Mr. MURPHY. The gentleman yields back. I now recognize the gentleman from Louisiana, Mr. Cassidy, for 5 minutes.

Mr. CASSIDY. Hello, Administrator Hyde.

Ms. HYDE. Hi.

Mr. CASSIDY. A couple things. Clearly, we are in a time of budgetary constraints. You referred to it multiple times, but on the other hand, that is the new reality. That said, it seems a luxury to be unfocused in how we are implementing programs. I had to step out several times, I apologize, but I gathered one of the things I heard you say is that there are many working definitions of severe mental illness. Now, truly, this seems like an area that you, your agency could give guidance as to what severe mental illness is about.

One example, one of the witnesses on the next panel speaks about how there is an unbalance in your compendium of care. She formerly worked with yours, says that of 288 programs listed, only four would address things pertaining to schizophrenia or bipolar disease. Now, first, knowing that our money is tight, why out of 288 programs will we only have four that seem to directly pertain to what we could all agree would be severe mental illness?

Ms. HYDE. I don't agree with those numbers. I don't know exactly where that comes from.

Mr. CASSIDY. She is a psychiatrist formerly with SAMHSA. You can read her testimony but she ballparked it. She goes, listen, maybe there is a couple I missed. Let's say that there is 8, there is 12, but out of 288 it seems like 286 should be related to something that we could all agree was severe mental illness. Is something wrong with that logic?

Ms. HYDE. The issue of serious mental illness is different for different purposes. So there is literally congressional definitions. There is definitions——

Mr. CASSIDY. So I am coming back to the fact that knowing in a time of budgetary constraint, when, by the way, in the shadow of Sandy Hook I think we are compelled not to accept that there are a lot of different definitions but to try and hone down at least in programmatic funding upon something that if there was a psychiatrist at the Agency in a position of authority, she would say, wow, this is how we prevent another Sandy Hook, put our resources there as opposed to a lot of other things which are more diffuse.

Ms. HYDE. I am not aware of any of SAMHSA's programs that are targeted to serious mental illness that doesn't include schizophrenia. It is not just——

Mr. CASSIDY. OK. But our point is that there is——

Ms. HYDE [continuing]. Schizophrenia, however——

Mr. CASSIDY [continuing]. A maladjustment of the compendium of care that there is only four programs—let's say for the sake of argument it is 12 out of 288 that are specifically focused upon what we could all agree would be serious mental illness.

Ms. HYDE. I am sorry. I just don't agree with the numbers. As I told you earlier——

Mr. CASSIDY. So if she comes up with that, would you agree in concept—because her testimony is next—in concept would you agree that if that is true that that would be an unbalanced compendium of care?

Ms. HYDE. I don't agree that that is true.

Mr. CASSIDY. But if it were true, would you accept that, just a hypothetical if you can go with me that there really should be a focus of these programs—in fact, your answer implies that you think it should be. There should be a focus of these programs upon those that we can agree would be severe mental illness?

Ms. HYDE. I think I have said several times there is a priority on serious mental illness.

Mr. CASSIDY. And how do you define priority?

Ms. HYDE. Seventy-five to eighty percent of our funding for mental health goes to people with serious mental illness or serious emotional disturbance, which is——

Mr. CASSIDY. OK.

Ms. HYDE [continuing]. The name for our children's programs.

Mr. CASSIDY. OK. Now, that said, severely mental ill patients, I see a lot of these grants go for prevention, but you can't really prevent paranoid schizophrenia. I mean we don't know the biologic basis in terms of a prevention activity.

Ms. HYDE. Actually, there is increasing evidence that we can prevent the disability related to those psychotic illnesses, and the earlier we intervene, the more we can have a positive impact——

Mr. CASSIDY. So when you say prevention, you don't technically mean prevention of the illness; you mean prevention of the untoward effects of having mental illness.

Ms. HYDE. Prevention has a range of issues in it. From—the Institute of Medicine has a whole range from primary prevention all the way up to intervention.

Mr. CASSIDY. Is there primary prevention of paranoid schizophrenia?

Ms. HYDE. No, I don't think we have the ability to do that at this point.

Mr. CASSIDY. So my problem again, in an era of budgetary constraints, should we be focusing our dollars on that which actually would prevent another Sandy Hook or should we be more diffuse? And let me ask you that. Do you agree with that question?

Ms. HYDE. I think we should do everything we can to prevent incidents like Sandy Hook.

Mr. CASSIDY. So does that mean again yes or no that we should focus our limited dollars upon those activities not exclusively but would primarily focus our limited dollars on those activities that would definitely have the potential to prevent such an incident like that?

Ms. HYDE. I think that is why the President has proposed the 2014 budget, several programs that we believe will help identify that and help——

Mr. CASSIDY. And so you do agree that we should focus our dollars because that is actually not a yes or no answer. And I don't mean to be confrontational, but that is——

Ms. HYDE. We have no choice as public administrators but to focus our dollars and we do that every day.

Mr. CASSIDY. OK. Great. I am almost out. I yield back.

Mr. MURPHY. I thank the gentleman. I just want to point out, I am looking at a document that SAMHSA put out called Mental Health: United States 2010. And in that on page 11 SAMHSA does define serious mental illness. Among adults, it is defined as "persons 18 or older who currently or at any time in the past year had a diagnosable mental, behavioral, or emotional disorder and resulting in substantial impairment in carrying out major life activities." So I am assuming diagnosable. So you do have a definition. I know we have been going back-and-forth on that but that is helpful and I should focus on that.

We have finished our questions but I do want to ask a favor of you if I can. I know one of the things that you have said frequently is you are not aware about some of the programs you fund and you asked for some of our feedback on those. So I have a personal request. On the next panel a man named Joe Bruce is going to testify and I know you are very busy, but Mr. Bruce's testimony, he said he is going through something that no parent or husband should ever have to experience.

His son William, after being discharged from a mental health treatment center with the assistance of a representative from the SAMHSA-funded Protection and Advocacy for Individuals with Mental Illness program murdered his mother. And it is also Mr. Bruce's wife, and he murdered her with a hatchet. I believe his story is very powerful and important and I think it is important for you to hear what one of the agencies you funded has done in this instance. So if you can stay just to hear his 5 minutes of testimony, I would be grateful if you could do that.

And with that, we end this panel and we will prepare the second panel to come up. Thank you.

Ms. HYDE. Thank you.

Mr. MURPHY. I will start to introduce our witnesses as they are taking their seats. I will introduce the witnesses of the second panel.

Our first witness is Joseph Bruce, the father of a son who suffers from severe mental illness. Our second witness is Dr. E. Fuller Torrey. He is a research psychiatrist specializing in schizophrenia and bipolar disorder and founded the Treatment Advocacy Center and executive director of the Stanley Medical Research Institute, which supports research on schizophrenia and bipolar disorder. He is also a professor of psychiatry at the Uniform Services University of the Health Sciences.

Our third witness is Dr. Sally Satel, a psychiatrist trained at Yale University School of Medicine. Since 2001 she has been a resident scholar at the American Enterprise Institute and also continues part-time clinical work in drug treatment clinics in Washington, D.C.

And our fourth witness is Dr. Joseph Parks. He is the chief clinical officer at the Missouri Department of Mental Health. There, he is responsible for clinical standards and quality of care for persons with mental illness, mental retardation, and developmental disabilities and alcohol and drug dependence. In this capacity, he has substantial experience working on SAMHSA-funded grants.

I will now swear in the witnesses. And you are aware the Committee is holding an investigative hearing. When doing so, we have the practice of taking testimony under oath. Do any of you have any objections to testifying under oath?

All have responded no.

The chair then advises you that under the rules of the House and the rules of the Committee, you are entitled to be advised by counsel. Do you desire to be advised by counsel during your testimony today?

All have said negative.

In that case, if you would please rise, raise your right hand, I will swear you in.

[Witnesses sworn.]

Mr. MURPHY. Let the record show all witnesses have answered in the affirmative.

You are now under oath and subject to the penalties set forth in Title XVIII, Section 1001 of the United States Code. You may now each give a 5-minute summary of your written statement. I will call upon you first, Mr. Bruce, for your statement. Thank you for being here.

TESTIMONY OF JOSEPH BRUCE, FATHER OF A SON WITH SEVERE MENTAL ILLNESS; E. FULLER TORREY, FOUNDER, TREATMENT ADVOCACY CENTER; SALLY SATEL, RESIDENT SCHOLAR, AMERICAN ENTERPRISE INSTITUTE; AND JOSEPH PARKS, III, CHIEF CLINICAL OFFICER, MISSOURI DEPARTMENT OF MENTAL HEALTH

TESTIMONY OF JOSEPH BRUCE

Mr. BRUCE. My name is Joe Bruce. I live in Caratunk, Maine. On February 6——

Mr. MURPHY. Pull the microphone real close to you, please. Thank you.

Mr. BRUCE. On February 6, 2006, my son William Bruce, age 24, was involuntarily committed to Riverview Psychiatric Center in Augusta, Maine. On April 20, 2006, with help from federally funded patient rights advocates from the Disability Rights Center of Maine, Will was discharged early from Riverview without the benefit of any medication.

As is most often the case with severely and persistently mentally ill persons across the country, Will returned home. Fears his mother and I had voiced to his doctors that Will would hurt or kill someone came true. On June 20, 2006, I returned home to find the body of my wife Amy. Will, in a state of deep psychosis, had killed her with a hatchet.

Will was advised that without his consent, his parents had no right to participate in his treatment or have access to his medical records. Will believed there was nothing wrong with him and that he was not mentally ill, a condition characteristic of many persons with severe bipolar disorder or paranoid schizophrenia, particularly of younger ages such as Will's. He would not consent to our involvement with his treatment, and because he was an adult, his mother and I were barred from all access to his treatment. The doctor's decision to release him, which resulted in such a tragic outcome, was made without the benefit of all of Will's history or any input from Amy and me.

After his commitment to Riverview by the criminal court, I applied to become his guardian. Will was agreeable to this until, incredibly, a patient advocate told him the guardianship is a bad idea. It would give your father complete power over you.

The attending physician, a new doctor, undoubtedly at the urging of DRCM, refused to provide the evaluation required in the guardianship application. He told me, I could never participate in anything that would cause your son to be considered an incapacitated person. Bear in mind that at this point in time, Will had been placed in the hospital after being found incompetent to even stand trial.

Suffice it to say, I finally did become guardian, and I was able to participate in Will's treatment and to obtain the medical records of his prior treatments. Until then, I had not known the role that patient advocates had played in Will's premature and unmedicated release.

The medical records revealed exactly what the patient advocates had recklessly done and said to encourage Will to avoid the treatment he so desperately needed. His doctor had recorded verbatim what the patient advocates said to Will in the meetings from which Amy and I had been excluded. The patient advocate, a Trish Callahan, told the treating doctor that DRCM regarded Amy and me as a "negative force in Will's life." Amy and I had never met any of these people or even heard of Disability Rights of Maine.

In the treatment meetings, she acted like a criminal defense lawyer. She openly coached Will on how to answer the doctor's questions so as to get Will the least treatment and the earliest release. She did this in the face of strongly contrary evidence of Will's unsuitability for unmedicated release. She repeatedly pressed for his early release despite knowing or recklessly disregarding that he was unsuited for it.

DRCM willfully neglected Will's need for treatment, and their pressure on the doctor to release Will led directly to Amy's death. But neither the patient advocates nor the DRCM has ever acknowledged they did anything wrong. They have not changed their procedures, and Trish Callahan, the advocate who helped fuel Will's paranoid hostility towards his mother and contributed to her death, continued to work on the same unit at Riverview for years afterwards.

Lest anyone believe this is a local, isolated occurrence, the National Disability Rights Network, responding to the Wall Street Journal's page 1 article concerning Will's case, defended the actions of DRCM, and even prepared talking points to deflect criticism. The patient advocates can do this with impunity because they are literally accountable to no one. But my experience with the patient advocates did not end here. I have come to know the stories of many families, and their experience with the advocates' surprising approach to these issues.

Beginning in 2007, I joined with other family members of some of the most severely mentally ill individuals in the State of Maine to seek legislative change to laws that had prevented our loved ones from receiving treatment. We took our concerns to the lawmakers in the Maine legislature. To the shock of all of us, we met with fierce lobbying opposition from Disability Rights Center of Maine. Nonetheless, we were successful in obtaining helpful legislation in 2007 providing for medication over objection in appropriate cases. Having failed in the legislature, the lawyers at DRCM filed a legal action challenging the law, which thankfully was unsuccessful.

At the time of Amy's death, the courts in Maine only had two options at a commitment hearing: to place someone in the hospital or to release them unconditionally. In 2008 and 2009 I and other family members worked to give the court a third option, that of releasing an individual into the community on the condition that he remain on medication. These types of laws are known as Assisted Outpatient Treatment laws and they have been opposed across the Nation by PAIMI organizations. Maine was no exception.

DRCM mounted a well-orchestrated attack on the proposed AOT law. It was joined in this effort by the Advocacy Initiative Network of Maine, another SAMHSA-funded organization. Their campaign included proffering 20 or so consumer witnesses in opposition to the law, but these consumers were completely aware of their mental illness, stable on medication and successfully living in the community, the very goals that the proposed law was designed to achieve for our loved ones. DRCM had persuaded them to oppose the law by misrepresenting its essential provisions. This cynical opposition to the AOT law—which failed, because the law was ultimately enacted—shocked me and the families. The incident illustrates the national policy of the PAIMI program to oppose any form of involuntary treatment.

The PAIMIs, like DRCM, are so concerned that one person may be inappropriately treated involuntarily that they seek to prevent anyone from being medicated. In Will's case, once I became his guardian, medication over his objection was his route to recovery.

As another example of DRCM's lobbying influence in this area, while the Maine families and I were busy working on the AOT law, DRCM was successful in getting a bill through the Maine legislature to make it more difficult for families to become guardians. Becoming a guardian is the only way families of adult patients can be involved in the treatment of their loved ones where the patients are unwilling or unable to consent. Why do PAIMIs want guardianship to be more difficult? Because guardianship lifts HIPAA secrecy and allows the guardians into the treatment meetings.

Will is still in Riverview, to which he was committed by the criminal court. Once he was committed, he got the care he should have gotten before. Ironically and horribly, Will was only able to get treatment by killing his mother. We have found a medication that works. He leaves the hospital frequently on supervised release with staff or family members. He is being successfully treated and he is doing extremely well. He now recognizes that if he had been treated, his mother would still be alive today. He stated to the Wall Street Journal, "the advocates didn't protect me from myself. None of this would have happened if I had been medicated."

Tragedy visits families every day. That is a sad fact of life. But an unbearable aspect of Amy's death is that my own tax dollars helped make it possible. A retired nurse from Riverview may have summed it up best. She wrote: "Mr. Bruce, your losses didn't happen for reasons other than your family's misfortune to become involved with the mental health system, when politics now overrides sound medical decisions."

Thank you for hearing my testimony. I would be happy to answer any questions.

[The prepared statement of Mr. Bruce follows:]

HOUSE COMMITTEE ON ENERGY AND COMMERCE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

Examining SAMHSA's Role in Delivering Services to the Severely Mentally Ill

Statement of Robert "Joe" Bruce and Exhibits

10:00 a.m.
May 22, 2013

My name is Joe Bruce. I live in Caratunk, Maine.

On February 6, 2006, my son William Bruce, age 24, was involuntarily committed to Riverview Psychiatric Center in Augusta, Maine. On April 20, 2006, with help from federally funded patient rights advocates from the Disability Rights Center of Maine (DRCM), Will was discharged early from Riverview without the benefit of any medication.

As is most often the case with severely and persistently mentally ill persons across the country, Will returned home. Fears his mother and I had voiced to his doctors that Will would hurt or kill someone came true. On June 20, 2006 I returned home to find the body of my wife Amy.[1] Will, in a state of deep psychosis, had killed her with a hatchet.[2]

Will was advised that without his consent, his parents had no right to participate in his treatment, or have access to his medical records. Will believed there was nothing wrong with him, that he was not mentally ill, a condition characteristic of many persons with severe bipolar disorder or paranoid schizophrenia, particularly of younger ages such as Will's. He would not consent to our involvement with his treatment, and because he was an adult, his mother and I were barred from all access to his treatment. The doctor's decision to release him, which resulted in such a tragic outcome, was made without the benefit of all of Will's history or any input from Amy and me.

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[1] Pictures of Amy and Will appear behind Tab 1.

[2] A transcript of my call to the 911 operator is annexed behind Tab 2.

After his commitment to Riverview by the criminal court, I applied to become his guardian. Will was agreeable to this until, incredibly, a patient advocate told him, "The guardianship is a bad idea. It would give your father complete power over you."

The attending physician (a new doctor), undoubtedly at the urging of DRCM, refused to provide the evaluation required in the guardianship application. He told me, "I could never participate in anything that would cause your son to be considered an incapacitated person." Bear in mind that at this point in time, Will had been placed in the hospital after being found incompetent to even stand trial!

Suffice it to say, I finally did become guardian, and I was able to participate in Will's treatment and to obtain the medical records of his prior treatments. Until then, I had not known the role the patient advocates had played in Will's premature and unmedicated release.

The medical records revealed exactly what the patient advocates had recklessly done and said to encourage Will to avoid the treatment he so desperately needed. His doctor had recorded verbatim what the patient advocates said to Will in the meetings from which Amy and I had been excluded.

> – The patient advocate, a Trish Callahan, told the treating doctor that DRCM regarded Amy and me as a "negative force in Will's life." Amy and I had never met any of these people or even heard of Disability Rights Center of Maine.
>
> – In the treatment meetings, she acted like a criminal defense lawyer. She openly coached Will on how to answer the doctor's questions so as to get Will the least treatment and the earliest release. She did this in the face of strongly contrary evidence of Will's unsuitability for unmedicated release.

– She repeatedly pressed for his early release despite knowing or recklessly disregarding that he was unsuited for it.[3]

DRCM willfully neglected Will's need for treatment, and their pressure on the doctor to release Will led directly to Amy's death. But neither the patient advocates nor the DRCM has ever acknowledged they did anything wrong. They have not changed their procedures and Trish Callahan, the advocate who helped fuel Will's paranoid hostility towards his mother and contributed to her death, continued to work on the same unit at Riverview for years afterwards.

Lest anyone believe this is a local, isolated occurrence, the National Disability Rights Network, responding to the Wall Street Journal's page one article[4] concerning Will's case, *defended* the actions of DRCM,[5] and even prepared talking points to deflect criticism.[6] The patient advocates can do this with impunity because they are literally accountable to no one. But my experience with the patient advocates did not end here.

I have come to know the stories of many other families, and their experiences with the advocates' surprising approach to these issues.

Beginning in 2007, I joined with other family members of some of the most severely mentally ill individuals in the State of Maine to seek legislative change to laws that had prevented our loved ones from receiving treatment. We took our concerns to the lawmakers in the Maine legislature.

To the shock of all of us we met with fierce lobbying opposition from Disability Rights Center of Maine. Nonetheless, we were successful in obtaining helpful legislation in 2007

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[3] A summary of the patient advocate's statements and actions appears behind Tab 4, and a more detailed chronology of Will's medical records appears behind Tab 5.

[4] A copy of the Wall Street Journal's August 16, 2008 article, "A Death in the Family, is annexed behind Tab 7.

[5] A copy of the NDRN response to the Wall Street Journal's article is annexed behind Tab 8.

[6] A copy of the NDRN's talking points is annexed behind Tab 9.

providing for medication over objection in appropriate cases. Having failed in the legislature, the lawyers at DRCM filed a legal action challenging the law, which thankfully was unsuccessful.

At the time of Amy's death, the courts in Maine only had two options at a commitment hearing: to place someone in the hospital or to release them unconditionally. In 2008 and 2009 I and other Maine families worked to give the court a third option, that of releasing an individual into the community on the condition that he remain on medication. These types of laws are known as Assisted Outpatient Treatment laws and they have been opposed across the Nation by PAIMI organizations. Maine was no exception.

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As another example of DRCM's lobbying influence in this area, while the Maine families and I were busy working on the AOT law, DRCM was successful in getting a bill through the

Maine legislature to make it *more difficult* for families to become guardians. Becoming a guardian is the only way families of adult patients can be involved in the treatment of their loved ones where the patients are unwilling or unable to consent. Why do PAIMIs want guardianship to be more difficult? Because a guardianship lifts HIPAA secrecy and allows the guardians into the treatment meetings.

* * *

Will is still in Riverview, to which he was committed by the criminal court. Once he was committed, he got the care he should have gotten before. Ironically and horribly, *Will was only able to get treatment by killing his mother.* We have found a medication that works. He leaves the hospital frequently on supervised release with staff or family members. He is being successfully treated and he is doing extremely well.[7] He now recognizes that if he had been treated his mother would still be alive today. He stated to the Wall Street Journal, "The advocates didn't protect me from myself. None of this would have happened if I had been medicated."

Tragedy visits families every day. That is a sad fact of life. But an unbearable aspect of Amy's death is that my own tax dollars helped make it possible. A retired nurse from Riverview may have summed it up best. She wrote: "Mr. Bruce . . . Your losses didn't happen for reasons other than your family's misfortune to become involved with the mental health system, when politics (now) override sound medical decisions."[8]

Thank you for hearing my testimony. I would be happy to answer any questions you might have.

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[7] Behind Tab 3 is a transcript of the hearing that resulted in Will's commitment to Riverview, in which a psychiatrist testified to the "remarkable change" that occurred in Will's condition once he was given antipsychotic medications. At page 51.

[8] A copy of the nurse's letter is annexed behind Tab 10. She has given me permission to use it publicly.

Exhibits to the Testimony of Joe Bruce

1. Pictures of Amy and Will.
2. Transcript of Joe Bruce's call to 911 operator, June 20, 2006.
3. Transcript of hearing in *State of Maine v. William Bruce*, March 27, 2007. (Once Will started antipsychotic medication in December 2006, it brought about "remarkable change" in his insight into his need for treatment. At 51.)
4. The Role of the Patient Advocates, A Summary of the Medical Records of William Bruce, prepared by Robert D. Owen, counsel to Joe Bruce.
5. William Bruce: Chronology of His Medical Records and Treatment, prepared by Robert D. Owen, counsel to Joe Bruce.
6. Preliminary Appointment as Guardian, *In Re: William H. Bruce*, Piscataquis County (Me.) Probate Court, Feb. 8, 2007.
7. "A Death in the Family: Aided by advocates for the mentally ill, William Bruce left the hospital -- only to kill his mother," WALL ST. J., August 16, 2008.
8. National Disability Rights Network "Summary in Response to WSJ Article."
9. National Disability Rights Network talking points memo.
10. Letter dated Dec. 16, 2006 to Joe Bruce from Maria Champine, a registered nurse who worked at Riverview.

Mr. MURPHY. Thank you, Mr. Bruce. And our hearts are with you and your family. I know you made references to a number of documents. You ask that these be submitted in the record and the minority has no objection. We will include these in the record then. Thank you.

Dr. Torrey, you are recognized next for 5 minutes.

TESTIMONY OF E. FULLER TORREY

Dr. TORREY. Thank you very much.

Mr. MURPHY. Microphone on and close to your mouth, please.

Dr. TORREY. Thank you very much, Chairman Murphy, Ms. DeGette. Very, very important what you are doing. It is not as sexy as the IRS hearings but it is just as important.

I am here to describe why I think SAMHSA is not only a failed federal agency but it has been so for 30 years. That is one of the qualifications I don't like. This is not a new issue. This is not just something that falls on Ms. Hyde. This is something that has been going on for 30 years really unlooked at by Congress in any serious—and so I strongly commend you for doing what you are doing.

I also want to emphasize that is not a Democratic or Republican issue. The—SAMHSA has been a failed agency. It was originally put together under the Bush Administration. It was a failed agency under the Clinton Administration, under the George Bush Administration, and it is continuing to be a failed agency under the Obama Administration. I would like to illustrate that by six points.

Point number one—and I am emphasizing what they should be doing compared to what they really are doing. Mass killings are increasing. We have heard that today. About half of the mass killers have serious mental illness, mostly schizophrenia, Seung-Hui Cho, Jared Loughner, James Holmes being only examples of them. There is no question they are increasing. SAMHSA does not seem to see this is a—this is not a priority for them at all.

We have talked about the fact that their 3-year plan has nothing about these problems but talks completely about behavioral health problems. A 4-year-old with tantrums having behavioral health problem, I understand that. A 12-year-old skipping school has problems. Somebody who goes down and kills 30 first-graders doesn't have a behavioral health problem; he has a severe mental illness and that should be recognized as such.

We now know that these are severe mental illnesses. I have a tremor of my left hand that is an early Parkinson's disease. This is not a behavioral health problem; this is a brain disease, just as schizophrenia, bipolar are brain diseases. These are twins that we looked at many years ago, now showing the one on the right who has schizophrenia, identical twins, has larger ventricles. There are now literally hundreds of studies showing that severe mental illnesses like this are brain diseases on it. Severe mental illness has been defined for Congress. It was defined by the mental health NIMH Advisory Council at the request of Congress in 1994 on it.

SAMHSA does not understand. It has no expertise on severe mental illness. Its last psychiatrist who had any expertise, Ken Thompson, left 3 years ago. The one psychiatrist was retained as an expert only on substance abuse, and the psychiatrist they just hired only has expertise on substance abuse, a very good woman but has no expertise on severe mental illness.

When SAMHSA was asked to bring a psychiatrist to testify before the Vice President Biden's committee, they brought in Dr. Daniel Fisher, who doesn't believe schizophrenia exists. He thinks it is a severe emotional distress, a spiritual experience. Mr. Cho and Loughner and Holmes were not having a spiritual experience. They were having a brain disease that needs treatment.

We have effective treatments. We have medication, we have assisted outpatient treatment. We know that assisted outpatient treatment will decrease hospitalizations in several different studies, decrease homelessness in one study, decreased victimization, decrease arrests in four studies, decrease violent behavior in three studies, and saves money in two studies. We have all kinds of evidence that this is a very effective treatment for people, especially who don't recognize that they are sick.

There is no evidence of that at all in SAMHSA, and in fact, SAMHSA has funded, as you have already heard today, programs, in my count, 14 States protection and advocacy consumer groups that have actively opposed the use of outpatient—assisted outpatient treatment and other effective treatments, including the States of many members of this committee on it.

Three, there is the issue of the unawareness of illness, and we know now there is about 20 studies showing the people who are not aware of their illness have differences in their brain, those people with schizophrenia on it. We need to pay attention to that. Instead, what they do is they find Alternatives Conference, as you have heard. I will answer the question from the Congressman of Tennessee. We estimate the cost of a single Alternatives Conference is about $500,000, and although SAMHSA appears to be feeling that they are short of money, 2 weeks ago they funded and approved for funding the conference for this year on it.

Another issue is the shortness of psychiatric beds. SAMHSA doesn't pay any attention to that but does have an international office and has an interest in psychiatric beds in Iraq and held conferences in Cairo and Amman on that.

Severe mental illness in jails and prisons is about 400,000. This is not a priority for SAMHSA. SAMHSA instead is concerned with putting out reading books, "Wally Bear and Friends," sticker books, et cetera.

Finally, last but not least, federal money to support severe mental illnesses are among the fastest-growing items in the federal budget, including federal funds for psychoses. That was the most expensive of all the nine chronic diseases, three times more expensive than the cost of diabetes on it. SAMHSA, this is not a priority.

In 2010 I asked about several questions about, for example, why do some States have three times more patients on severe mental illnesses on SSI and SSDI? SAMHSA had no answers to any of these questions and did not answer, and the reason why I know they didn't have any is because they were very busy. Number one, they were——

Mr. MURPHY. The gentleman's time is expired. Can you wrap up with a final moment? Are you ready to wrap up?

Dr. TORREY. Sorry.

Mr. MURPHY. So your time expired. Can you wrap up with whatever final statements you are going to make on this?

Dr. TORREY. Ten seconds of a video?

Mr. MURPHY. Yes.

[Video shown.]

Dr. TORREY. This is what they were spending $80,000 on, which is their annual songfest that they have in early December on it. This cost about $80,000 and involved all the members and was their attempt to bring attention to substance abuse. And my argument is that people who have $109,000 as an average salary don't need to be told that substance abuse is a big issue on it.

Thank you very much. I just want to again emphasize how important what you are doing is. And if Congress doesn't act at this point, then we are going to have additional problems under the next Clinton or the next Bush or the next Obama Administration.

Mr. MURPHY. Thank you.

Dr. TORREY. Thank you.

[The prepared statement of Dr. Torrey follows:]

"Examining SAMHSA's Role in Delivering Services to the Severely Mentally Ill"

Summary of testimony of E. Fuller Torrey, M.D. to the House Subcommittee on Oversight and Investigation, May 22, 2013

1. SAMHSA is a $3.5 billion federal agency with 574 employees. It defines its core mission as reducing "the impact of substance abuse and mental illness on America's communities." Severe mental illnesses include conditions such as schizophrenia and bipolar disorder, as defined in 1992 by the National Advisory Mental Health Council in response to a request from Congress. One would expect SAMHSA to be concerned about severe mental illnesses since SAMHSA acknowledges that 9.8 million adult Americans have such illnesses.
2. Among the major mental illness problems in the U.S. are increasing mass killings; the underutilization of treatments known to be effective in such cases; a shortage of psychiatric beds; increasing number of mentally ill inmates in jails and prisons; and rapidly increasing federal costs. Except for a brief mention of the problems of jails and prisons, none of these problems are priorities for SAMHSA.
3. In contrast to the above, SAMHSA spends millions of dollars supporting programs which actively oppose effective treatments; funds an annual anti-treatment national conference; is more concerned about psychiatric bed availability in Iraq than in the U.S.; produces picture books for children; commissions paintings ($22,500); and holds an annual staff musical ($80,000).
4. Thus, SAMHSA priorities have virtually no relationship to national needs.
5. SAMHSA has been a failed federal agency for 30 years, spanning two Democrat and two Republican administrations. It is not a partisan problem but rather a national problem.

U.S House of Representatives Committee on Energy and Commerce

Subcommittee on Oversight and Investigations

Hearings on the Substance Abuse and Mental Health Services Administration (SAMHSA):

"Examining SAMHSA's Role in Delivering Services to the Severely Mentally Ill"

May 22, 2013

Testimony of E. Fuller Torrey, M.D.

Chairman Murphy and Ms. DeGette, thank you for inviting me to testify on this important issue. I am a psychiatrist specializing in the treatment of individuals with severe mental illnesses, especially schizophrenia and bipolar disorder. I am a retired career officer in the U.S. Public Health Service and currently the Executive Director of the Stanley Medical Research Institute, which spends $40 million each year in private funds for research on schizophrenia and bipolar disorder. I am also the founder of the Treatment Advocacy Center, a non-profit group which advocates for better treatment for individuals with severe mental illness.

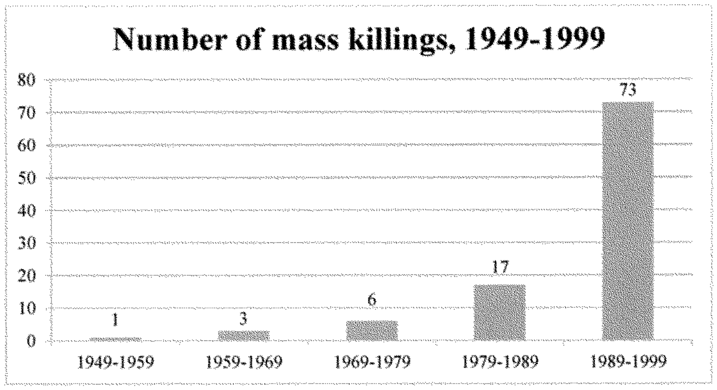
I am here to testify regarding SAMHSA's role in delivering services to the severely mentally ill. SAMHSA is a $3.5 billion agency which has been designated by the Dept. of Health and Human Services (DHHS) as the lead federal agency for services to individuals with mental illness and/or substance abuse problems.

When the federal government receives inquiries regarding mental illness issues, such as occurred following the tragedies in Tucson, Aurora, and Newtown, these inquiries are usually referred to SAMHSA for response. SAMHSA defines its core mission as reducing "the impact of substance abuse and mental illness on America's communities." This is an important mission.

I will illustrate today how SAMHSA is failing badly in fulfilling that mission. SAMHSA is, in fact, a very troubled federal agency. But let me clearly state at the outset that this failure is not a Democrat or Republican failure. The failure of SAMHSA is a politically equal opportunity failure. SAMHSA was put together in 1992 from the remnants of existing failed programs from other agencies by President George H. Bush. It continued to be a failed agency under Presidents Bill Clinton and George W. Bush, and is now continuing this tradition of failure under President Barack Obama. I wrote critically of SAMHSA's failed programs during the first Bush administration ("Hippie Healthcare Policy," *Washington Monthly,* April 2002*)* and have also done so during the Obama administration ("Bureaucratic Insanity," *National Review*, June 20, 2011). To politicize SAMHSA and blame its failure on one party or the other is to miss the point.

I will summarize the failures of SAMHSA by contrasting six types of activities **SAMHSA should be doing** with six types of activities **SAMHSA actually is doing.**

(1) SAMHSA should be concerned with the fact that mass killings associated with untreated severe mental illnesses are increasing in the United States. This has now been demonstrated by three studies.[1,2,3] The most extensive of the studies was done by the *New York Times* and showed a dramatic rise in mass killings between 1949 and 1999.



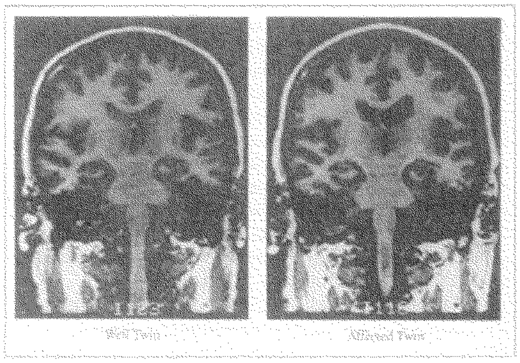
All three studies concluded that a majority of the perpetrators were mentally ill, e.g. Seung-Hui Cho, Jared Loughner, and James Holmes, all of whom had schizophrenia.

Schizophrenia is one form of severe mental illness as defined by the National Advisory Mental Health Council in 1992, in response to a request from Congress. In addition to schizophrenia, severe mental illnesses were said to include schizo-affective disorder, bipolar disorder, autism, and severe forms of depression, obsessive-compulsive disorder, and panic disorder. SAMHSA acknowledges that 9.8 million American adults suffer from these illnesses.

What is SAMHSA actually doing? Severe mental illnesses appear to have a very low priority at SAMHSA. In its current three-year plan defining its priorities ("Leading Change: A Plan for SAMHSA's Roles and Actions, 2011-2014"), a 41,804 word document, there is no mention whatsoever of schizophrenia, schizo-affective disorder, bipolar disorder, severe depression, or obsessive-compulsive disorder, and a single mention of panic disorder.

SAMHSA's failure to focus on severe mental illnesses was also illustrated by its response to the Newtown mass killings. A Task Force under Vice-President Joseph Biden was convened to make recommendations regarding how such tragedies could be averted in the future. Pamela Hyde, Administrator of SAMHSA and a member of the Task Force, recommended that insurance coverage for mental illness treatment should be improved and that the early identification of individuals with mental illness should also be improved. In fact, insurance coverage and early identification were not problems for Seung-Hui Cho, Jared Loughner, James Holmes, Adam Lanza, or most other perpetrators of these tragedies. The SAMHSA response therefore completely missed the core problem, which is how to guarantee treatment for such severely mentally ill individuals once they are identified.

To support the SAMHSA position it invited a psychiatrist, Dr. Daniel Fisher, to testify before the Biden Task Force. SAMHSA had to invite an outside psychiatrist because it has nobody among its 574 staff who has expertise on severe mental illness. For the past 3 years, it has employed only one psychiatrist but his expertise is exclusively substance abuse treatment. Dr. Fisher stated categorically to the Task Force that mental illness and violence are not linked, an assertion that is contradicted by more than 20 studies.[4] Dr. Fisher, whose organization receives $330,000 each year from SAMHSA, is unusual in his belief that schizophrenia is not a disease of the brain, an assertion that is contradicted by literally hundreds of studies. This picture of identical twins, one of whom has schizophrenia, is illustrative.



Well Twin

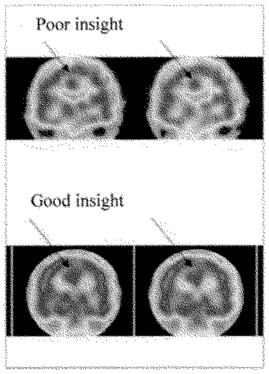
Affected Twin

Rather Dr. Fisher describes the condition called schizophrenia as "severe emotional distress" or "a spiritual experience." This is apparently consistent with SAMHSA's position.

(2) SAMHSA should be promoting treatment programs which have been proven to decrease violent behavior in individuals with severe mental illnesses. An example of such a program is conditional release which, in a study in New Hampshire, was shown to reduce violent episodes by half.[5] Assisted outpatient treatment (AOT) has also been shown to be highly effective in reducing hospitalizations, incarcerations, and episodes of violence. In North Carolina AOT reduced violent behavior from 42 to 27 percent.[6] In New York AOT reduced the number of individuals who "physically harmed others" from 15 to 8 percent in one study.[7] In another study, AOT reduced by 88 percent the chances of the mentally ill individual being arrested for a violent crime.[8]

What is SAMHSA actually doing? SAMHSA's three-year plan includes no mention whatsoever of these effective treatment programs. Ignoring such programs is bad enough, but it gets worse. SAMHSA actually funds many programs which lobby to *block the implementation of these effective programs in* the states. An example is the California Network of Mental Health Clients which has been funded by SAMHSA for almost two decades with as much as $200,000 per year. This organization has actively lobbied to prevent the implementation of AOT, called "Laura's Law", in California. The California Network of Mental Health Clients lost much of its state money in 2012 when it was publicly revealed that its acting director had used the organization's credit card to bail himself out of jail after being charged with drunken driving.[9] SAMHSA has funded similar organizations under its consumer grant program and its Protection and Advocacy grant program that have *actively impeded the implementation of improved treatment laws in* many other states, including Connecticut, Florida, Maine, Maryland, Michigan, Nevada, New Jersey, New Mexico, New York, Pennsylvania, Utah, Vermont and Wisconsin.

(3) SAMHSA should be concerned about the fact that many individuals with severe mental illnesses—including Cho, Loughner, Holmes and Lanza—are unaware of their own mental illness and thus are very unlikely to seek treatment voluntarily. This unawareness is a result of their brain disease and is referred to as anosognosia. At least 18 studies of schizophrenia have reported differences in the brains of individuals with and without awareness of their illness. This poses major problems for treatment; the need to treat such individuals before they commit an act of violence must be weighed against the protection of that individual's civil liberties.



Brain scans of two individuals with schizophrenia

What is SAMHSA actually doing? SAMHSA does not acknowledge that some individuals with severe mental illnesses must be treated involuntarily because they lack awareness and are potentially dangerous to others as a result of their illness. Instead, SAMHSA sponsors an annual conference for individuals with severe mental illnesses at which individuals are encouraged to *not* take their medication. This federally-sponsored conference, called "Alternatives," is the largest anti-psychiatry, anti-treatment meeting in the United States. Speakers at this conference make claims such as the following: "What is called schizophrenia in young people appears to be a healthy transformational process that should be facilitated instead of treated." At the 2010 conference, at which the SAMHSA administrator gave the opening talk, one speaker claimed that schizophrenia is *caused* by the antipsychotic drugs used to treat it. Another speaker called severe mental illnesses "extreme states of consciousness that are mad gifts to be nurtured and cultivated." Workshops such as "Coming off medications: A harm-reduction approach," were widely available.

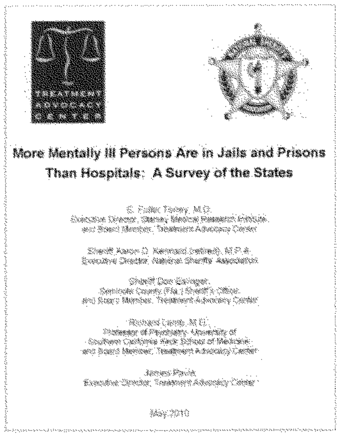
The annual "Alternatives" conference costs at least $500,000 in federal dollars each year; SAMHSA pays the conference sponsor $127,000 for administrative costs and many of the approximately 1,000 attendees use SAMHSA funds to pay for transportation and hotels. Early this month SAMHSA approved funds for a similar conference this year.

(4) SAMHSA should be concerned about the severe shortage in hospital beds for individuals with severe mental illness. Over the past half century 96 percent of state mental hospital beds for treating mentally ill individuals have been closed. The United States now has the same number of such beds, per population, as were available in 1850. According to experts in these fields, we now have less than one-third the number of beds which are needed for adequate psychiatric care.[10]

What is SAMHSA actually doing? SAMHSA has publicly expressed virtually no concern about the severe shortage of psychiatric hospital beds in the United States. SAMHSA appears to be too busy with concerns about mental illness issues in other countries. SAMHSA has an International Office and in 2005 and 2006 "sponsored two Action Planning Conferences on Iraq Mental Health…in Amman, Jordan and Cairo, Egypt." SAMHSA also sponsored 11 teams of "Iraqi behavioral health providers" who were brought to the U.S. in 2008 and 2010 to visit "trauma services, substance abuse services, and children's mental health services." One of the outcomes of the SAMHSA-sponsored meetings on Iraq mental health was a decision to close the Al-Rashad Mental Hospital in Baghdad, despite the already severe shortage of beds in that city. SAMHSA has also been involved in helping Afghanistan "build its mental health programs and capacity."

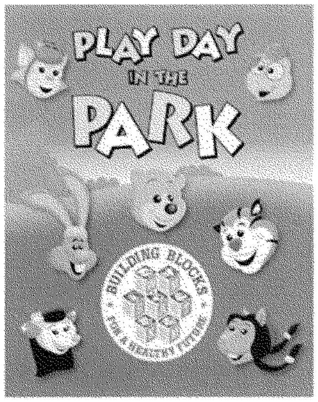
(5) SAMHSA should be concerned that there are now more than three times more persons with severe mental illnesses in jails and prisons than in hospitals.

In the 1970s the percent of jail and prison inmates with severe mental illnesses was said to be 5 percent. In the 1980s it was 10 percent; in the 1990s 15 percent; and from 2000 to 2010 it was 20 percent.[11] It is not unusual now to see estimates of 25 percent or more.



More Mentally Ill Persons Are in Jails and Prisons Than Hospitals: A Survey of the States

What is SAMHSA actually doing? The incarceration of mentally ill persons in jails and prisons is not a priority for SAMHSA. It appears to be too busy with what it apparently regards as more important problems. For example, it produces and distributes free of charge reading books for children such as "Play Day in the Park" and "Wally Bear and Friends." It also produces online children's games such as "The Great Weather Race" and "Boogie Band Studio" as well as children's sticker sets with stickers saying "My Smile is Beautiful" and "I love you." SAMHSA also makes available hundreds of brochures on a wide variety of topics, e.g. "Hurricane Recovery Guides Preparedness Planning", "Oil Spill Response: Making Behavioral Health a Top Priority." Almost none of the SAMHSA brochures include anything about severe mental illnesses.



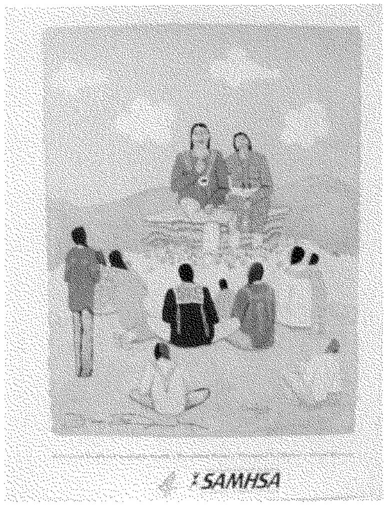
(6) SAMHSA should be concerned that federal expenses for the care of individuals with severe mental illnesses are among the fastest growing federal budget items. Federal Medicaid, Medicare, Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) associated with mental illness have risen sharply over the last three decades. "The total increase in these four programs between 1986-87 and 1997-98 was $2.6 billion per year, making them among the most rapidly growing programs in the federal budget."[12] Over the past decade these programs have continue to rapidly increase. Even allowing for inflation, the United States is now spending 12 times more per capita on mental illness than it was a half century ago.

What is SAMHSA actually doing? In 2010 I asked SAMHSA for information on why federal costs for mental illness were increasing so rapidly, including the following questions:

- Why do some states have more than three times more mentally ill individuals, per population, on SSI and SSDI than other states do?
- What is the percentage of mentally ill individuals on SSI and SSDI who are not receiving treatment?
- What is the percentage of Americans with serious mental illnesses who are receiving SSI and/or SSDI?

The answers SAMHSA provided on November 19, 2010 were as follows: "We have no data"; "there is no source of this data to our knowledge"; and "SAMSHA does not have access to this information."[13] SAMHSA could collect such data if it wished to do so; its data collection branch is one of its few effective components. As the lead federal agency for mental health services, one might have expected SAMHSA to be interested in these questions, and to collect such information if it did not exist.

SAMHSA apparently had no interest in such questions since at that time it was focused on other projects which it apparently deemed to be more important.[9] One of these was the commissioning in 2010 of a



painting for $22,500 by New Mexico artist Sam English. This painting, which was officially unveiled on March 8, 2011, shows a group of Native Americans. According to the press release put out by SAMHSA at the time of the painting's unveiling, it "was commissioned to help raise awareness about the roles of families and the community in mental and substance use disorder prevention." I believe everyone is aware that families are important, but how this painting was supposed to "raise awareness", and whose awareness was supposed to be raised, is unclear. To try and answer these questions I went to the SAMHSA headquarter to see the painting. However the guard at the door would not let me in and told me that I would need to call ahead and get a special appointment to see the painting.

The other project that SAMHSA was preoccupied with in November 2010, was final preparations for the SAMHSA annual staff musical. This took place on Dec. 1-3, 2010, with three performances attended by most of SAMHSA's 574 staff members. According to the SAMHSA news release, the musical depicted characters who use drugs and "experience consequences of their behavior, including addiction and HIV/AIDS," and finally "recognize the need to seek help." The cost of the musical was over $80,000, including staff time. It is unclear what the musical was supposed to accomplish. Since the average salary of SAMHSA's 574 employees is $109,000, it can be

presumed that they all were aware that alcohol and drug use may have adverse consequences, and they should not need a musical to tell them that.

In summary, SAMHSA is, and has been since its creation 30 years ago, a failed federal agency. It is not a Democrat or Republican failure but rather a joint political failure. What I wish to emphasize most strongly is that this failure has consequences that affect us all. The issue is not merely what SAMHSA is doing—the waste of taxpayer money on projects like antipsychiatry conferences, the commissioning of paintings, or staff musicals. Many federal agencies waste money. The important issue is what SAMHSA is *not doing* to improve the broken mental illness and substance abuse treatment system in the United States. Because people with severe mental illnesses are not receiving treatment, tragedies occur every day of which Tucson, Aurora and Newtown are merely the most prominent. And unless Congress acts to improve this situation, such tragedies will continue to occur.

Thank you for your attention.

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[1] Hempel AG, Meloy JR, Richards TC. Offenders and offense characteristics of a nonrandom sample of mass murders. *Journal of the American Academy of Psychiatry and Law* 1999, 27:213-225.

[2] Fessenden F. They threaten, seethe and unhinge, then kill in quantity. *New York Times*, April 9, 2000.

[3] Follman M, Aronsen G, Pan D. A guide to mass shootings in America. *Mother Jones*, December 15, 2012.

[4] Torrey EF. *The Insanity Offense: How America's Failure to Treat the Seriously Mentally Ill Endangers Its Citizens.* New York: W.W. Norton, 2008. Pp. 140-148, 229-234.

[5] O'Keefe C, Potenza DP, Mueser KR. Treatment outcomes for severely mentally ill patients on conditional discharge to community-based treatment. *Journal of Nervous and Mental Diseases* 1997, 185:409-411.

[6] Swanson JW, Borum R, Swartz MS, et al. Can involuntary outpatient commitment reduce arrests among persons with severe mental illness? *Criminal Justice and Behavior* 2001, 28:156-189.

[7] *Kendra's Law: Final Report on the Status of Assisted Outpatient Treatment* (New York State Office of Mental Health, March 2005).

[8] Link BG, Epperson MW, Perron BE, et al. Arrest outcomes associated with outpatient commitment in New York state. *Psychiatric Services* 2011, 62:504-508.

[9] Branan B. $3 million in state contracts yanked from Sacramento mental health group. *Sacramento Bee*, November 11, 2012.

[10] Torrey EF, Entsminger K, Geller J, et al. No room at the inn: trends and consequences of closing public psychiatric hospitals 2005-2010 (Treatment Advocacy Center, July 2012).

[11] Torrey EF, Kennard AD, Eslinger D, et al. More mentally ill persons are in jails and prisons than hospitals: a survey of the states (Treatment Advocacy Center, May 2010).

[12] Torrey EF, *The Insanity Offense*, pp. 168-169.

[13] Letter from Frances M. Harding, Director of the Center for Mental Health Services, SAMHSA, Nov. 19, 2010.

Mr. MURPHY. Dr. Satel, you are recognized for 5 minutes.

TESTIMONY OF SALLY SATEL

Dr. SATEL. Thank you, Representatives Murphy, DeGette, and——

Mr. MURPHY. Microphone, and pull it close. Thank you. Press the button so it is green.

Dr. SATEL. Thank you for inviting me to be here today.

Mr. MURPHY. It is not on yet. Do you have a green button? It is lit up?

Dr. SATEL. I apologize.

Mr. MURPHY. Thank you.

Dr. SATEL. Thank you for inviting me to be here today. I am a resident scholar at the American Enterprise Institute, and as a psychiatrist, I do some work at a local methadone clinic. And from 2002 to 2006 I was a member of the National Advisory Council of the Center for Mental Health Services.

My point today is that SAMHSA does not adequately serve the sickest individuals despite its statutory mission to do so. To start with, the Agency has adopted an idiosyncratic interpretation of its very mission. I am referring to something called the Recovery Model. The Recovery Model, according to SAMHSA's definition as its guiding philosophy, is "a process of changes through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential." Well, living a self-directed life and reaching one's full potential is an excellent aspiration and I try to accomplish that with my patients as well, so I am not here to criticize the spirit of that model.

What I am here to do is to underscore how inappropriate it is for the sickest patients. We are talking about individuals here who are too psychotic to participate in their own self-directed life, too paranoid, too terrorized by hallucinations, too lost in delusional thoughts. Fifty percent of them, as Dr. Torrey just alluded to, don't even recognize they have an illness, and if they don't have insight into the problem, there is no way they are going to be able to "collaborate in creating a detailed life plan," which is part of SAMHSA's agenda for the mentally ill, or "determined their own unique path."

They are the most vulnerable of CMHS's constituency. They are the sickest silent minority who languish in back bedrooms and jail cells and homeless shelters. And CMHS does not hear from them. Instead, they hear from consumers, which is the word—politically correct word for patient—consumers who are able to be directed. They don't hear from the folks who are most impaired, nor do they hear from their caregivers, the clinicians who get their hands dirty in the trenches with these most desperate patients, or even from some of those patients themselves who, once they are improved, can acknowledge that mainstream psychiatry has been helpful for them and medications as well. They don't hear from them. They hear from consumer survivors who claim to speak for all patients, but obviously don't do that.

This imbalance has concerned me for years. When I was on the Advisory Council from 2002 to 2006, we repeatedly were trying to have some input into the decisions regarding the grants that were approved but it was clear that we were pretty much there to rubberstamp those grants. They had already been approved. We asked repeatedly if we could see them prior to approval or if we could review them after approval and then have our assessment be reconsidered, and we were turned away every time. My colleague—I mentioned a colleague—actually, his name should appear in my testimony. It is Dr. Jeffrey Geller, who is a professor at University of Massachusetts, but he followed me or we overlapped a bit on the Council, and what he told me was he and fellow members during those years just gave up at attempts for meaningful input and left in disgust.

Finally, I will turn to the kinds of programs that serve as a model for the kinds of programs that SAMHSA hopes, states will enact. This is through—it is a national registry of evidence-based programs and practices. And here, there is a striking imbalance. What I mentioned in my testimony was of the 228 programs, four specifically mentioned severe mental illness in their description. Now, that doesn't mean only four attend to severe mental illness, but it is striking that even some of the others who did not mention severe mental illness talked about patients who were—I will give you one example here—designed for patients motivated to manage their mental health issues. Again, these are patients whose psychotic symptoms are in check. They are not the most disturbed.

And what is also very striking about this registry of programs is the fact that it pointedly omits AOT, assisted outpatient treatment. As Dr. Torrey described what those are, I won't go into it.

Briefly, a word about prevention. No, we cannot enact primary prevention in the mentally ill, severely mentally ill. We don't understand the brain mechanisms yet that cause it.

I will end with two recommendations. One would be really to Administrator Hyde, which is to abandon the Recovery Model that is the umbrella philosophy and take advice as well from parents, clinicians, and the sickest but improved patients who have something constructive to offer. Don't fund groups that are anti-psychiatry in their agenda. It is like the CDC funding activists who would tell people with HIV not to take their antiretrovirals or not to have protected sex. And consider directing the Secretary to commission an independent review of the scientific soundness of the studies listed on that registry about which ones are there and which ones are missing and should be included.

Thank you very much for your time.

[The prepared statement of Dr. Satel follows:]

U.S. House of Representatives Committee on Energy and Commerce
Subcommittee on Oversight and Investigations

Hearings on the Substance Abuse and Mental health Services Administration

Examining SAMHSA's Role in Delivering Services to the Severely Mentally Ill

Testimony of Sally Satel, MD

May 22, 2013

Representatives Murphy, DeGette, and other members of the Subcommittee:

Thank you for inviting me to testify today. I am a psychiatrist trained at Yale University School of Medicine. I served on the faculty until 1993. Since leaving Yale I have continued clinical work, part time, in drug treatment clinics in Washington D.C., and, since 2001, I have been a resident scholar at the American Enterprise Institute.

From 2002 to 2006 I was a member of the National Advisory Council of the Center for Mental Health Services (CMHS), the agency within SAMHSA charged with funding services for individuals who are mentally ill.[1] At that time, I expressed concerns privately to the head of SAMHSA, and publicly in published articles, that CMHS was failing to provide adequate federal leadership in the care of people with severe psychiatric disorders. By this term I refer to individuals afflicted by schizophrenia, bipolar disorder, severe depression (often with psychotic features), and related psychotic conditions.

In the time I have today, I first wish to describe what I believe are two major sources of SAMSHA's dereliction in attending to the sickest individuals. These are (1) its idiosyncratic interpretation of its very mission – one that fosters models of care that many chronically psychotic people are not capable of using, and (2) a dearth of psychiatrists in leadership position. These two dynamics have played a significant role in shaping the agency's overall orientation towards the severely mentally ill. Next, I will outline the

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[1] To Fight Stigmas, Start With Treatment, *New York Times*, April 29, 2009 at http://www.nytimes.com/2009/04/21/health/21mind.html
Sane Mental Health Laws? Don't Hold Your Breath *The Weekly Standard* May 28, 2006 at http://www.sallysatelmd.com/html/a-ws8.html
Commission's Omission - The President's Mental-health Commission in Denial. *National Review* July 9, 2003 at http://mentalillnesspolicy.org/mentalhealth/new-freedom-commission.html

manifestation of SAMSHA's vision in the kinds of the programs it advances as models of care under its National Registry of Evidence-based Programs and Practices.

SAMHSA's Understanding of its Mission

The Recovery Model - SAMHSA's guiding philosophy of care for all mental disorders, no matter the severity, is the "recovery model." In 2004, the agency convened a conference at which the recovery model was formalized: "By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path toward those goals." A 2012 SAMHSA newsletter framed recovery as "A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."[2]

Many can benefit from the Recovery Model. But so many cannot, as I will discuss in a moment.

The recovery emphasis reflects a chief recommendation of the 2003 New Freedom Commission on Mental Illness in a report commissioned by President George Bush. The commission focused on people who are willing and able to make use of treatments, programs, and opportunities. Notably, the commission even prided itself on soliciting testimony from constituents, stating, "Nearly every consumer...expressed the need to fully participate in his or her plan for recovery." The commission suggested that sufficient therapy, housing options, and employment programs will enable people with schizophrenia or manic-depressive illness to take charge of their lives.

Now, I recognize that many patients who have been diagnosed with these disorders can lead lives that are much more fulfilling and productive than some clinicians ever imagined and that some clinicians don't pay enough attention to what a particular patient wants and to what he values in his or her life.

The problem is that some patients are too sick to take advantage of treatment, to collaborate in creating a detailed life plan, or to determine their own "unique path." I am referring here to the fact that over half of all untreated people with a psychotic illness do not acknowledge there is anything wrong with them, a condition technically called anosognosia. This is a neurological problem caused by disruption of the mechanisms within the brain that mediate our capacity to reflect upon ourselves. They are the most vulnerable of CMHS' constituency, yet the agency invests not nearly enough in their wellbeing.

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[2] http://www.samhsa.gov/samhsanewsletter/Volume_20_Number_3/Fall2012-volume-20-number-3.pdf

Indeed, during its hearings, the Commission did not hear from the sickest silent minority that is languishing in back bedrooms, jail cells, and homeless shelters. They are too paranoid, oblivious, or lost in psychosis to attend hearings, let alone testify at one.

This is a good place to point out that SAMSHA, too, receives much of its input – intentionally and selectively so in my view -- from so-called "consumer-survivors" to claim to speak for all patients. This creates significant distortion: the agency asserts that it is responsive to its constituents when, in fact, its most impaired constituents cannot advocate for themselves. What's more, the views of other patients who would indeed able to participate more fully in their care, but also recognize the value of mainstream psychiatry and readily say they benefit from it, are not routinely, if at all, solicited. [3]

The problem with the recovery vision is that it is a dangerously partial vision. The emphasis on recovery as a goal steers policy away from the needs of the most severely disabled. SAMHSA forthrightly acknowledges that it sees the "consumer" who can "fully participate in his plan for recovery" is its primary constituent, not the dependent patients who need quality psychiatric care.[4] This imbalance needs to be corrected.

Dearth of Professional Psychiatric Input at CMHS

SAMHSA makes an inadequate contribution to the treatment of individuals with severe psychiatric disorders because it is under-populated by staff with expertise in the nature of their treatment needs.

During my tenure on the CMHS National Advisory Council, I attempted to have some input into the CMHS decisions regarding what projects should be funded. Despite the fact that we were called an "advisory council," it was clear that CMHS did not want our advice. Rather than being able to see proposals ahead of time, we were presented with the approved proposals as a fait accompli at the time of the meeting. Thus SAMHSA not only had little

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[3] http://phenomenologyofmadness.wordpress.com/2013/05/11/on-problems-inside-the-movement/ See also, http://www.treatmentadvocacycenter.org/resources/briefing-papers-and-fact-sheets/159/467

[4] Interview with Kathryn Power, CMHS Director circa 2003 – 2008 http://www.accessmylibrary.com/coms2/summary_0286-35121827_ITM. Power is the Regional Administrator, Region One for the Substance Abuse and Mental Health Services Administration, where she continues to promote that philosophy.

in-house expertise on serious psychiatric disorders (I recall a single public mental health psychiatrist) it also failed to take advantage of the expertise on its own advisory council.

My colleague, Jeffrey Geller MD, Director of Public Sector Psychiatry at the University of Massachusetts Medical School, who served on the CMHS Advisory Council from 2004-2008, had a similar experience. "Most members who served during the years I served, gave up attempts for meaningful input and left in disgust," he notes. They had repeatedly asked then-CMHS director, Kathryn Power, that the grant proposals "be provided to Council members in advance of the meetings, [that we have] time and opportunity for meaningful exchange on the merits of a proposal at the meeting, and/or revisions and re-review of the proposals...We were rebuffed each and every time."[5]

Unbalanced Compendium of Care

SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP) is an online "registry of mental health and substance abuse interventions that have been reviewed and rated by independent reviewers. The purpose of this registry is to assist the public in identifying scientifically based approaches to preventing and treating mental and/or substance use disorders that can be readily disseminated to the field."[6] When a program is certified as evidence-based by SAMHSA, state mental health departments are encouraged to use block grant money for them.

On its website, http://www.nrepp.samhsa.gov/ViewAll.aspx, SAMHSA lists 288 separate evidence based programs (ideally understood to mean demonstrated in clinical trials, subjected to peer review and successful replication). Among the almost 300 studies, are many sound programs to treat substance abusers and drug offenders (e.g., Motivational Enhancement Therapy; Moral Reconation Therapy, Oxford House), enhance parenting skills, support caregivers, prevent HIV, etc. Broad-focus programs such as "Enhance Wellness" (an exercise and education program for adults with physical illnesses) and "Coping Cat" (to help children recognizes symptoms or anxiety) may well be useful if well executed, but, crucially, like the vast majority of programs listed in the Registry, these are not intended for the sickest of individuals.

The striking nature of the NREPP repertoire of programs is its imbalance.

Programs for the Mentally Ill -- Of the 288 programs listed, four by my count, specifically designated people with severe illness as their recipients (Compeer, Critical Time Intervention, Housing First, and Psychiatric

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[5] Personal communication, May 12, 2013

[6] http://www.nrepp.samhsa.gov/ViewAll.aspx

Rehabilitation Process Model). Among those, the Rehab Process Model is "client" centered and aimed at "encouraging self-determination," again the recovery agenda with its intrinsic limitations, while Compeer is aimed at reducing isolation (a most noble aim, but, by design, not about treatment itself). Housing First is an excellent program for people who need minimal supervision and can comply with rules. Critical Time Intervention provides time-limited case management, under supervision of a psychiatrist or psychologist, to prevent homelessness and other adverse outcomes in people with serious mental illness following discharge from hospitals, shelters, prisons and other institutions. This program is notable as is it most narrowly aimed at a highly vulnerable subpopulation.

A handful of other programs (Modified Therapeutic Community, and International Center for Club House Development, Wellness Recovery Action Planning, WRAP) do not specifically mention severe mental illness in their description, but presumably serve those patients as well. WRAP, in particular, is only eight weeks long. It is "designed to create a safe, nonjudgmental autonomy supportive environment in which people feel motivated to manage their mental health issues."[7] Again, it is a program aimed at patients whose psychotic symptoms are in check. Worth noting as well, a recent assessment contains no measures of re-hospitalization, incarceration, or homelessness.[8]

Even if I missed some programs in my review of the synopses of all 288 programs listed, it is abundantly clear that services aimed specifically at the most desperately ill – or, more precisely, those in the most intense phase of their psychotic illness – represent only a small minority of the NREPP programs.

Furthermore – and remarkably -- NREPP neglects one of the most effective and best-studied programs for individuals with severe mental illnesses: Assisted Outpatient Therapy (AOT). AOT is a form of civil court-ordered community treatment, which is often necessary for those who have a reliable pattern of falling into a spiral of self-destruction or dangerousness when off medication. To date, studies have shown that it reduces hospitalizations; homelessness; both arrest and victimization of mentally ill people, and violent behavior. [9] Two studies document that AOT saves money. [10]The Department of Justice has certified AOT as an effective crime prevention program[11] Despite numerous attempts by

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[7] http://www.mentalhealthrecovery.com/wrap/documents/SchizophrBull-2011-Cook-schbul_sbr012.pdf
[8] ibid.
[9] http://mentalillnesspolicy.org/kendras-law/research/kendras-law-studies.html; http://www.treatmentadvocacycenter.org/about-us/our-reports-and-studies/471
[10] http://www.treatmentadvocacycenter.org/storage/documents/aot_saves_money.pdf
[11] http://www.crimesolutions.gov/ProgramDetails.aspx?ID=228

families of people with mental illness to raise the profile of AOT at the agency, such programs remain unrecognized by NREPP.[12]

Primary Prevention Agenda of Block Grant Not Relevant to Severe Mental Illness

SAMHSA focuses heavily on the prevention of mental illness and substance abuse.

Prevention and severe mental illness is a puzzling concept because we know little about the biological causes of conditions such as schizophrenia and bipolar disorder. These are primarily diseases of the brain but our understanding of the underlying brain mechanisms is still in the early stages. Absent this knowledge, prevention is not possible. Therefore, SAMHSA's focus on prevention has virtually nothing to contribute to the well-being of individuals with severe mental illnesses.

Clearly, SAMSHA's net is wide: In its instructions to the states on how the federal block grant funds should be spent, SAMHSA instructs them to "make general prevention and primary prevention priorities." States are also told that: "The focus is about everyone, not just those illness or disease, but whole population. The focus is on prevention and wellness activities." [13]Inclusive as it is mission is, the agency makes relatively minimal room for the most needy.

Conclusion and Recommendations

In summary, SAMHSA is the federal agency created by Congress in 1992 to provide leadership on severe illness (among other aspects of mental health), yet little leadership is to be found within its walls. That CMHS does not have any psychiatrists in a leadership position is, frankly, astounding. Imagine the National Institute of Mental Health employing no neuroscientists in key roles. "Home, health, purpose, and community," SAMHSA's stated priorities, are supremely laudable goals but only – and this is a critical point – only for people who are motivated to to attain them and able to make use of help.

Unfortunately, the Center for Mental Health Services has a skewed understanding of its constituency—no surprise, really, as its mission is refracted through the lens of the "recovery model." The agency's guiding ideology leads it to overlook millions of people with long-term psychotic disorders. Very few SAMHSA programs help reduce the impact of mental illness on the communities – that is, on rates of incarceration,

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[12] http://feedback.samhsa.gov/forums/148531-closed-help-samhsa-highlight-advances-of-the-beh/suggestions/2580341-implementation-of-assisted-outpatient-treatment and http://feedback.samhsa.gov/forums/148531-closed-help-samhsa-highlight-advances-of-the-beh/suggestions/2586918-court-ordered-outpatient-treatment; http://feedback.samhsa.gov/forums/77283-closed-samhsa-s-strategic-initiatives/suggestions/1155179-increase-use-of-assisted-outpatient-treatment

[13] http://www.samhsa.gov/grants/blockgrant/docs/BGapplication-100312.pdf p 39

homelessness, and dangerousness.

The agency's relative neglect of those with severe mental illness is only part of the problem. As the testimony of other panelists will make clear, the agency also supports activities that actively sabotage their welfare. This is strong language, I am aware. I refer here to CMHS's seemingly uncritical support of both "consumer" groups and legal aide workers (though its Protection and Advocacy, PAIMI, program) who either condemn the use medications or are hostile to formal psychiatric care. The efforts of these advocates have been decidedly harmful to patients with schizophrenia and other psychotic illnesses.

I respectfully recommend that:

Consider directing the Secretary of HSS to commission demonstration projects of Assisted Outpatient Treatment (e.g. Kendra's Law in New York, Laura's Law in California) throughout the country.

Consider directing the Secretary to commission an independent review of the scientific soundness of NREPP programs, paying particular attention to effective programs for severe mental illness that should be included in the NREPP.

Consider directing the Secretary to review personnel hiring policies at SAMHSA with the goal of introducing more psychiatrists and psychologists who have direct clinical expertise in delivering publicly funded care to people with severe psychiatric disorders.

Consider redefining the goals of PAIMI by limiting its role to protection and disallowing lobbying of state legislatures on commitment laws

It is my hope that today that this Congressional Subcommittee can begin to address these shortcomings I've outlined in my remarks.

Thank you for your attention.

Mr. MURPHY. Thank you, Dr. Satel.

Dr. Parks, you are recognized for 5 minutes.

TESTIMONY OF JOSEPH PARKS

Dr. PARKS. Good morning. I am Joseph Parks. I want to thank the chairman and Congresswoman DeGette for the opportunity to testify today. I am testifying today in my individual capacity and not on behalf of any organization.

I am a board-certified psychiatrist with specialty training in emergency psychiatry. I have served as the medical director for the Missouri Department of Mental Health for 20 years. For 3 years, I was the director of its overall mental health operation. Throughout my career, I have continued to see patients and I still see patients on a weekly basis. I have provided psychiatric service to harmlessly mentally ill persons in shelters and through assertive community treatment teams.

For the past 12 years I have been the president of the Medical Director Council of the National Association of State Mental Health Program Directors, and for the past 3 years, I have served as director of the Missouri Institute of Mental Health and professor at the University of Missouri St. Louis.

Through my various roles, I am very familiar with the SAMHSA Mental Health Block Grant and the Discretionary Grant programs. These programs are an important contribution to improving the lives of people with serious mental illness. I have been a principal investigator for SAMHSA Discretionary Grants, I have independently evaluated grants through my role at MIMH, and as Missouri Mental Health Division director, I was responsible for the execution of the block grant plan.

Although the amounts are modest and inadequate to meet the overall needs, the SAMHSA Mental Health Block Grant plays an important role in funding services for uninsured persons and services that are not payable through Medicaid, particularly in young adults who are not usually insured when they first become ill. Block grant funding has been especially critical to keep in place the full range of activities and services that a comprehensive state mental health system wants to have, including early identification and early intervention.

I specifically want to mention to the Committee that SAMHSA requires us when using the block grant if we are funding individual activities to spend them on persons with serious mental illness or children with SED. That is a requirement of how we use those funds.

Now, SAMHSA discretionary grants play an important role in implementing new evidence-based practices and improving the quality of care to people with serious mental illness. A good example is SAMHSA's Co-Occurring State Incentive Grants—they were called COSIG—which helped us improve the ability of community mental health centers and substance abuse treatment agencies to promptly and effectively serve people who have both mental illness and substance abuse conditions simultaneously. This is particularly important with respect to reducing violence by people with serious mental illness. The discretionary grants also fund technical assistance. In Missouri we got technical assistance to reduce the use of seclusion and restraint in our state hospitals, which reduced both patient and staff injuries.

Before I turn to policy recommendations, I would like to acknowledge in light of Oklahoma's tornadoes that SAMHSA gave significant support when we had tornadoes in Joplin in 2011 in Representative Long's district. They were instrumental in us getting care out to those people rapidly.

I want to make the following recommendations for improving treatment for people with serious mental illness and reducing violence: first, there is a growing shortage of psychiatrists. We need a national approach to increase the psychiatric workforce. Demand for psychiatric services is far outstripping the ability of the available workforce to supply timely needed care. Aging psychiatrists are retiring out faster than new graduates are taking their place. The current estimated gap by the EPA is about 45,000 psychiatrists short. Patients are not being seen for months and clinic and hospital psychiatric units are closing because they can't get the staff. There needs to be attention here.

Second, I would like to make recommendation for two specific discretionary grant directions. There should be grants available to implement mental health first aid training. This is an early identification, early intervention for mental illness that is a training with the general public similar to regular first aid. It is a national—it is being implemented nationally but it needs more support to roll it out to get people engaged before they become suicidal or violent.

Third, there needs to be a new round of the COSIG grants. Substance abuse increases the likelihood that somebody will be mentally ill significantly. Over half of people with mental illness have substance abuse problems. We need new grants in this area.

Regarding mandatory treatment, I would actually recommend greater support for mental health courts. I have been involved in providing mandatory treatment through different legal modalities, including inpatient and outpatient civil commitment, guardianship in mental health courts in three different States. In all three States the outpatient—had outpatient commitment laws and in all three States they were difficult to implement and used rarely primarily because local law enforcement doesn't have the resources and doesn't want to use their officers to follow up on people that are violating the commitment orders. Also, it is—mental health courts are more agreeable—are more acceptable to the courts, to law enforcement, and to the people with mental illness. I think they would be the best strategy.

Finally, to end my comments, there is an epidemic of premature death among people with serious mental illness. Research shows that people in the public mental health system, most of whom are seriously mentally ill, die an average of 25 years younger—in their mid-50s—than the general population. This is shorter than the life expectancy of someone with HIV and on a pier with sub-Saharan Africa. It is an unaddressed national tragedy.

People with serious mental illness should be federally designated as a health disparities population and their rates and causes of death should be monitored annually. HHS and SAMHSA should develop a national strategy that Congress should fund specifically for reducing these premature deaths, most of which are due to chronic medical conditions due to poor care. We need to promote the integration of behavioral health and general medical care and promote integrated preventive measures on both the healthcare side and the mental health side. Nobody recovers from their mental illness once they are dead of a heart attack, and that is what is killing our people with serious mental illness.

Thank you for the opportunity to present my views on these critical issues. I would be happy to assist the Committee in my various roles to help you implement solutions and address the needs of people with mental illness. This deserves national attention and leadership at all levels. It is greatly appreciated you holding this hearing.

[The prepared statement of Dr. Parks follows:]

Statement of Joseph Parks, M.D.

before the

Oversight and Investigations Subcommittee of the House
Committee on Energy and Commerce

on the

"Examination of SAMHSA's Role in Delivering Services to the
Severely-Mentally Ill."

May 22, 2013

"The health of the people is really the foundation upon which all their happiness and all their powers as a state depend."

Benjamin Disraeli, British Prime Minister, 1877

A. CREDENTIALS

My name is Joseph Parks, M.D.

I want to thank Chairman Murphy and Congressman DeGette for the opportunity to testify today at this hearing on the "Examination of SAMHSA's Role in Delivering Services to he Severely-Mentally Ill."

I am a board certified psychiatrist and was the first psychiatrist nationally to complete a fellowship in emergency psychiatry. I've served as Medical Director for the Missouri Department of Mental Health for 20 years. For three years I was the Director of its mental health operation.

For the past three years I have also served as Director of the Missouri Institute for Mental Health (MIMH) that is part of the University of Missouri St. Louis with the academic title of Distinguished Professor of Science. For the past 12 years I have been president of the Medical Directors Council of the National Association of State Mental Health Program Directors – also known as NASMHPD.

Throughout my career I have continued to provide direct patient care and I currently see patients at a federally qualified health center in Columbia, Missouri. I have previously been medical director of state hospitals in Chicago, Illinois, in Cincinnati, Ohio, and I have provided psychiatric services to homeless mentally ill patients in shelters and through assertive community treatment teams.

I have previously been part of the faculty of Department of Psychiatry at the University of Cincinnati, University of Chicago, and University of Missouri at Columbia. I'm testifying today in my individual capacity, and not on behalf of any organization.

B. Experience with SAMHSA

Through my role with the Missouri Department of Mental Health, I have been familiar with the SAMHSA Mental Health Bock Grant (MHBG) Program. In 2013, Missouri received MHBG funding in the amount of $7,495,010. Missouri's MHBG funds have only increased by 7.7 percent over its funding level in 2010, a rate of increase far below the rate of inflation in the cost of providing services. The Substance Abuse Block Grant is far larger – $25,895,523 in 2013 – but has actually gone down by 1.3 percent since 2010.

IN 2013, Missouri will use 93 percent of its MHBG funds for purchasing mental health treatment services for uninsured persons or purchasing services that cannot be covered by Medicaid, 2 percent will be spent on suicide prevention, and nearly 5 percent will be spent on administrative costs.

SAMHSA requires that 95 percent of MHBG funds must be spent on services and only 5 percent can be spent on administrative costs.

Through my role at Missouri's Department of Mental Health, I have also been familiar with SAMHSA's discretionary grants. I have been the principal investigator for suicide prevention grants and SBIRT (brief screening assessment and intervention for excessive drinking and risky drug use) grants.

In 2013, the Missouri Department of Mental Health received $4,395,873 in funding for six different discretionary grants from the Center for Mental Health Services (CMHS) at SAMHSA, and $7,679,234 in funding for three discretionary grants from the Center for Substance Abuse and Treatment (CSAT).

The six CMHS grants include:

- Improving the organization and delivery of mental health services across communities;
- Transitioning young adults from child mental health services to adult mental health services;
- Serving homeless mentally ill persons,
- Identifying very young children at risk for mental health problems and intervening early;
- A data reporting grant; and
- A youth suicide prevention grant.

The first three grants primarily target persons with serious mental illness and account for 63 percent of the total funding. The youth suicide prevention grant emanates from funds that are Congressionally designated and are to be used for that purpose.

Through my role as Director of MIMH, I am familiar with the evaluation of SAMHSA grants. The goals of the SAMHSA grants goals usually include a required evaluation component to determine how effectively they are implemented and what the outcome and results of the interventions. MIMH is currently evaluating 14 separate SAMHSA grants totaling $4,350,095 to nine different organizations. Only one of these grants is for consumer advocacy and it amounts to less than 1 percent of the total funding.

C. Role of SAMHSA in Serving Persons with SMI

Although the amounts are modest and inadequate to meet overall needs, the SAMHSA block grant funds play an important role in funding services for uninsured persons. Most people develop serious mental illness (SMI) in their late teens or 20s before they have established employment and prior to coverage under employment-based insurance. MHBG funds have been extremely helpful in covering the mental health needs for this population.

SAMHSA discretionary grants play an important role in implementing new evidence-based practices and improving the quality of care to persons with serious mental illness. Grant programs that have been particularly successful in Missouri in improving the quality of services to persons with mental illness include Co-Occurring State Incentive Grants (COSIG), which improve the ability of both community mental health centers and substance abuse provider agencies to serve persons that have both mental illness and substance abuse conditions concurrently. Prior to these grants it would be common for a person who had both serious mental illness and addiction to be told by the community mental health center that they could not be treated for their serious mental illness until their addiction was treated. Substance abuse treatment agencies would not treat them until their serious mental illness was stable.

With the COSIG grants, there is truly a "no wrong door" approach by community mental health centers and substance abuse treatment provider agencies in welcoming the person who needs treatment and engage those individuals immediately. This is a particularly important improvement with respect to reducing violence by persons with mental illness. The presence or absence of a substance use disorder is the major predictive factor of whether or not a person with mental illness will be more violent than a person without mental illness. The SAMHSA grants for reduction of seclusion and restraint have markedly reduced episodes of violence in our state hospitals.

SAMHSA discretionary grants also fund technical assistance to states. Missouri has received technical assistance in reducing seclusion or restraint from NASMHPD that was funded by SAMHSA. The landmark study by the NASMHPD Research Institute (NRI) that found that persons in public mental health systems died 25 years younger than the general population was implemented with SAMHSA funding.

The NASMHPD study was instrumental in creating a public dialogue about the need for integration of behavioral health in general medical care, and the role that serious mental illness plays in increasing the cost of general medical care in the Medicaid and Medicare programs. SAMHSA has responded nationally to this epidemic of death among persons with SMI by funding over 90 CMHCs nationally to provide integrated behavioral health and medical care.

SAMHSA has also emphasized that a modern mental health and addiction system in the states should have prevention, treatment and recovery support services available both on a stand-alone and integrated basis with primary care, and should be provided by appropriate organizations and in other relevant community settings. SAMHSA's proposed continuum comprises of nine domains, including:

- Health Homes
- Prevention and Wellness Services
- Engagement Services
- Outpatient and Medication Assisted Treatment
- Community Supports and Recovery Services
- Intensive Support Services
- Other Living Supports
- Out of Home Residential Services
- Acute Intensive Services

Block grant funding has especially critical for the full range of activities and services that a comprehensive state system should include such as early identification and intervention, supported housing, crisis services, all the way to inpatient services.

Moreover, these services are not only for individuals with a mental or substance use disorder, but also support their families who are critical to achieving recovery and resiliency.

Briefly, before I turn to specific policy recommendations, I also would like to acknowledge SAMHSA's substantial support during various state and regional natural disasters over the last few years. Due to the SAMHSA's leadership and the tools they have provided on a prospective basis, it has allowed state mental health agencies to be on the ground to lend assistance on many levels to residents devastated by recent hurricanes, tornados and flash floods in several states.

D. Recommendations for Improving Treatment of SMI and Reducing Violence

1) Increase the Resources Available through Both the SAMHSA Mental Health Block Grant and Discretionary Grants

SAMHSA resources have not kept pace with either the general rate of inflation in the cost of care or with the markedly increased demand for mental health services that has occurred in the last 10 years. It is critically important that Congress provide SAMHSA with appropriate funding so the agency can disseminate important tools to states and communities for improving the treatment of serious mental illness, and providing the early interventions that will be the most effective means of reducing violence that involve persons with serious mental illness.

2) Develop a National Approach for Increasing Psychiatric Workforce

The demand for psychiatric services is far outstripping the ability of the available workforce to supply timely, needed care. Severe workforce gaps are increasing and significantly restricting access to essential treatment services for persons with serious mental illness.

According to a University of North Carolina (UNC) 2008 study commissioned by the Health Resources and Services Administration (HRSA), the United States has a significant shortage of mental health professionals, especially "prescribers". The current supply of psychiatrists is at least 30,000 short of what is needed.

The projected demand for all physicians continues to rise outstripping the projected increase in physicians. For psychiatry, the anticipated demand has risen dramatically. The number of people seeking psychiatric services has increased because of the growing and aging population, mental health parity and anti-stigma efforts. The number of psychiatric problems has increased because of the economic downturn and the psychological toll of two wars. Other factors increasing the demand for psychiatrists are direct marketing of psychiatric medications to the public and an increase in the number of FDA black box warnings causing primary care clinicians to be reluctant to prescribe psychotropics. This is occurring at the same time that the projected supply of psychiatrists is flat.

Psychiatrists are not increasing in number because retirements are outnumbering those entering the workforce through training. Currently 55 percent of psychiatrists are older than age 55. In a recent projection using a similar methodology to the UNC study, the deficit has increased to 45,000. Patients often have to wait months to see a psychiatrist because clinics cannot find enough psychiatrists to hire to provide service. Hospitals have closed their psychiatric units due to difficulties in recruiting psychiatrists to staff those operations. Current national shortages in mental health professionals, specifically psychiatrists, will continue to exacerbate. All projections estimate the gap between unmet need and supply will widen substantially over the next 20 years.

3) Specific Discretionary Grant Recommendations

a. **Grants Funding Mental Health First Aid** – Early identification and treatment can prevent a mental illness from developing into a disability or leading to suicide or violence against others.

Mental Health First Aid (MHFA) is a groundbreaking public education program that helps the public identify, understand, and respond to signs of mental illnesses and substance use disorders. The idea behind MHFA is no different than that of traditional first aid: to create an environment where people know how to help someone in emergency situations. But instead of learning how to give CPR or how to treat a broken bone, the 8-hour course teaches people how to recognize the signs and symptoms of mental health problems and how to provide initial aid before guiding a person toward appropriate professional help.

The interactive 8-hour course is presented by instructors who have been certified through an intensive 5-day training. The course presents an overview of mental illness and substance use disorders in the U.S. and introduces participants to risk factors and warning signs of mental health problems, builds understanding of their impact, and overviews common treatments. Those who take the course to certify as Mental Health First Aiders, learn a 5-step action plan encompassing the skills, resources and knowledge to help an individual in crisis connect with appropriate professional, peer, social, and self-help care. Since its introduction in the U.S. four years ago, more than 50,000 people have been trained in 47 states and the District of Columbia. Mental Health First Aid can create community environments more alert to, and prepared to intervene in, the psychiatric distress, that leads to suicide and violence against others.

b. **Grants to Implement and Improve the Integrated Treatment of Substance Abuse Disorders and Mental Health Disorders in Persons with SMI** - The presence of substance abuse is the strongest predictor that persons with SMI will commit violence. We can do much better addressing substance abuse disorders in people with SMI.

c. **Grants Supporting Effective Early Treatment of Psychotic Illness** - Our nation's approach to helping people with psychotic illnesses like schizophrenia is shameful.

Usually, young people slip into psychotic illnesses for several years while they – or their families – get no help. When they have a "first psychotic break," they usually are briefly hospitalized. Almost always, medications take the worst of the symptoms away – within days or weeks. So then they are discharged with a referral to care and maybe a recommendation of a support group. This is woefully, stupidly deficient! Having symptoms reduced is not a cure. When people feel better, and especially since the drugs have significant side effects, they often stop taking the medications. Relapse is likely. Usually the second psychotic break is worse. And then the revolving door begins.

Often after decades people figure out how to manage their illness, but by then they are often on permanent disability status, unemployed, and in terrible health. Some have suggested that the solution to this problem is going backward – not forward – to the days when stays for individuals in psychiatric hospitals were measured in months and years. This is simply idiotic.

There is no research to suggest it is effective. It is terribly expensive. Hospitals cannot be run (as the old asylums were) on unpaid patient labor. And a civilized society cannot detain people on a vague hope they will get better. So we should not turn the clock back on mental health care. But we do need a modern approach to care for people with psychotic disorders, one that replaces both the asylum and the revolving door with continuous team treatment like that we provide for people with chronic medical problems. Teams delivering First Episode Psychosis (FEP) care have figured out how to do this work. It is person-centered, family driven, collaborative and recovery oriented. Staying in school or work is encouraged – though adaptations may be needed. It is time to implement this approach, as both Australia and Great Britain have done. We need not lag behind other nations in this area.

Our country needs to make modest investments now to develop FEP teams so that families anywhere in the state struggling with a young adult who is slipping away from sanity can get good care reasonably close to home. The Committee's attention to this issue could have an enormous positive effect.

4) Make HIPAA Work as it Was Originally Intended

Although HIPAA explicitly allows health care providers and providers of health care related services to share protected health information absent patient consent for the purposes of treatment, which includes care coordination, many health care providers continue to insist that they can only share protected health information with the patient's consent.

Adding additional groups with whom health care providers are allowed to share information, such as family members who are directly supporting the persons coordination of care, is unlikely to be successful when health care providers routinely interpret HIPAA as prohibiting sharing protected health information absent patient consent, even between other health care providers, when in fact that is what HIPAA explicitly allows.

These health care providers are taking an inappropriately restrictive interpretation of HIPAA in an attempt to reduce their personal and organizational liability, as opposed to taking an interpretation that maximizes the patient's best interests in receiving coordinated care. In short, their primary goal is not what is best for the patient but rather how best to limit their own liability risks. This is both clinically dangerous for patients because it results in information not being shared that would improve care decisions, and at the same time economically wasteful for the health care system in that it results in unnecessary repetition of assessments, tests, and hospitalizations.

There is a need for a national initiative to retrain health care providers to error on the side of sharing protected health information when it would benefit the individual receiving treatments. There is a need for a national strategy to make the perceived liability risk of not sharing information, when it could have been shared and the lack of sharing information results in patient harm, as great as or greater than the perceived risk of sharing information absent patient consent.

5) **Increase Federal Support for Mental Health Courts**

I have been involved in providing mandatory treatment through different modalities – including inpatient and outpatient civil commitment – guardianship, not guilty by reason of insanity processes, probate court orders and in mental health and drug courts in Ohio, Illinois, and Missouri.

All three states have outpatient commitment laws and in all three states they are difficult to implement and only used rarely. The major barrier has been the unwillingness of police and sheriff departments to commit resources to enforcing violations of commitment orders. Local law enforcement almost uniformly indicate that they do not have the resources in terms of officers available to assist with mental health treatment in this manner and that crimes the have been committed, or are being committed, are a higher priority for community safety. Police departments are usually quite effective in persuading the local judges to make orders for outpatient commitment rarely if at all.

There has been much more success nationally in implementing mental health courts were a person is required to accept treatment for their mental illness as a condition of probation or parole. This is more acceptable to local law enforcement because it helps keep mentally ill people out of their jails, more acceptable to the courts because it provides them with an additional option or disposition of the case, and more acceptable to the mentally ill person who is usually more ready to admit they have committed a crime then they are so to admit that they must have treatment is a civil probate requirement because they might do something dangerous in the future.

Regarding research outcomes for outpatient commitment, the most recent systematic review of outpatient commitment published up until November 2009 by the Cochrane Collaboration suggests that compulsory community treatment may not be an effective alternative to standard care. This research is on the effectiveness of compulsory community treatment for people with severe mental illness through a systematic review of all relevant randomized controlled clinical trials. Only two relevant trials were found and these provided little evidence of efficacy on any outcomes such as health service use, social functioning, mental state, quality of life or satisfaction with care. No data were available for cost and unclear presentation of data made it impossible to assess the effect on mental health state, and most aspects of satisfaction with care. In terms of numbers needed to treat, it would take 85 outpatient commitment orders to prevent one readmission, 27 to prevent one episode of homelessness, and 238 to prevent one arrest.

The reviewers concluded that Compulsory community treatment results in no significant difference in service use, social functioning or quality of life compared with standard care. People receiving compulsory community treatment were, however, less likely to be victims of violent or non-violent crime.

It is unclear whether this benefit is due to the intensity of treatment or its compulsory nature. There have been five new research studies made available since November 2009 awaiting inclusion in the review may alter the conclusions of the review once assessed. There is no Cochrane review available regarding mental health courts available at this time, however, the Cochrane review of drug courts is somewhat more hopeful concluding that they promising results for the reduction of drug use and criminal activity in drug using offenders.

The Cochrane Collaboration is an international network of evidence based practice reviewers. They are an independent, not-for-profit organization, funded by a variety of sources including governments, universities, hospital trusts, charities and personal donations. A systematic review is a high-level overview of primary research on a particular research question that tries to identify, select, synthesize and appraise all high quality research evidence relevant to that question in order to answer the question. There has been much more federal support available for implementing drug courts than there has been for mental health courts.

In view of the lack of compelling evidence for the effectiveness of mandated outpatient commitment and the reluctance of local law enforcement agencies to be involved, the best current strategy for increasing the availability of mandatory treatment for persons with serious mental illness would be to increase federal support for mental health courts -- which are easier to implement and more acceptable to both local law enforcement and the persons being mandated into treatment.

6) **We need additional block grant funds directed at reducing the devastating impacts of various forms of trauma (e.g., impact on individuals of natural disasters, child abuse, violence) that lead to mental health disorders in our society.**

Over 90 percent of public behavioral health clients have been exposed to trauma, and most have multiple experiences of trauma.

Millions of Americans suffer traumatic events due to range of incidents – rare or consistently over time. Over 90 percent of public behavioral health clients have been exposed to trauma, and most have multiple experiences of trauma.

SAMHSA has tried through limited funds to address the behavioral health impact of trauma by developing public health approaches to trauma that strengthens surveillance, screening, and treatment that better responds to the needs of those affected. Reducing the impact early is possible and cost-effective, and SAMHSA should receive increased funding to address the needs of people affected by traumatic episodes.

7) **Treat the Appalling Rate of Premature Death Among Persons with Serious Mental Illness in the Public Mental Health System like the National Epidemic It Is –**

It is been over 10 years now since research showed that persons in the public mental health system, most of whom have serious mental illness, are dying on average 25 years younger than the general population. This is a higher death rate than experienced currently by persons with HIV and on a par with sub-Saharan Africa. But what is overlooked is that over 80 percent of the premature deaths and years of life lost are due to co-occurring chronic medical conditions such as diabetes and heart ailments, not suicide or accidents. There is no federal agency that is routinely and systematically tracking this epidemic, let alone addressing it.

Key recommendations in this area include:

a. Persons with serious mental illness should be federally designated as a "distinct at risk health disparities" population;

b. The CDC and SAMHSA should develop, implement, and fund national annual surveillance of the mortality rates and causes of death in persons with serious mental illness; and
c. HHS and SAMHSA should develop, implement, and fund a national strategy specifically for reducing premature death among persons with serious mental illness by promoting and accelerating the integration of behavioral health care and general medical care – and integration of preventive measures on the health care side and mental health side.

Thank you again for the opportunity to present my views on these critically important issues that the Committee is tackling. I would be happy to assist the Committee in my various roles, to help you implement solutions to addressing the needs of people with serious mental illness.

They deserve national attention and leadership at all levels.

Mr. MURPHY. Thank you. I just recognize myself for 5 minutes.

Dr. Parks, you are opposed to assisted outpatient treatment; you say so in your written and oral testimony? Yes or no?

Dr. PARKS. I think—no, I don't think I can make a yes/no answer. What I am advising the Committee of is if you wish to increase access using mandatory methods, I think you will be more successful and get better implementation if you focus on mental health courts.

Mr. MURPHY. I understand, but with regard to getting treatment, courts don't provide treatment. Assisted outpatient treatment is an alternative that has been—we have heard testimony, read things that have been fought by some of these advocacy groups funded by SAMHSA.

Dr. Torrey, do you think assisted outpatient treatment, mandatory assisted outpatient treatment has a value and is there evidence to prove that?

Dr. TORREY. Obviously, assisted outpatient treatment is a proven entity at this point. Mental health courts are also good but it is important to recognize that mental health courts are merely being used because of the failure of the mental health treatment system as such. The other problem with mental health courts is you can't get treatment until you have broken a law, so if I said to you today we have a very good treatment for people with diabetes or hypertension but you have to break a law to get it, you would probably say that I deserve some treatment.

This is the problem of where we are now that we don't have any real treatment system out there and we are having to use the mental health courts. That is a sign of the failure of the system, not the good part of the system. But they work.

Mr. MURPHY. And Mr. Bruce, in your testimony, do you believe that if your son had been court-ordered to receive other treatment, inpatient or outpatient, that an outcome could have been different for him?

Mr. BRUCE. There is no question about it. He——

Mr. MURPHY. It is on. Just pull it closer. It was on. There you go. Now, it is off. The green light needs to be on. There should be a green light on there. Thank you.

Mr. BRUCE. My son responded to medication immediately. The testimony of Dr. Schottky at—a forensic psychiatrist who evaluated him for his trial talked about the difference between Will before—when she met him the first time unmedicated and then when she spoke to him again later after he had started taking Seroquel, and I knew immediately that he was on medication because he called me for the first time in 4 months or so and he was in tears and he said, Dad, I am sick.

And he is—Seroquel was not the right medication for him. He later began taking Abilify. But I take Will out to lunch in Augustine, Maine. We go shopping together. He—if you were to talk to him now, you wouldn't—there is no sign of delusions. He is able to plan and think. He has problems because of the length of time that he remained psychotic, but he is—if he had been on medication in 2006 and had been released from the hospital on a court order that said he had to remain on his treatment plan, that would have given him an opportunity for the medication to work and with the supporting treatment that is necessary in these kind of programs, I think that he would be living in a community somewhere probably with a job, and life would be a lot different for the Bruce family.

Mr. MURPHY. Thank you. Real quickly from each of the doctors I want to ask you a question. In the SAMHSA administrator's testimony she talked about the 5,000 additional mental health professionals also requested by the President, and listed in there to train social workers, counselors, psychologists, behavioral health professionals, marriage and family therapists, nurses, and other mental health professionals. Dr. Torrey, yes or no, do you think this should also include psychiatrists?

Dr. TORREY. Absolutely. I worked at the National Institute of Mental Health for many years. I can't conceive of a federally administered program for people with mental illnesses that does not include psychiatric input on it.

Mr. MURPHY. Dr. Satel, do you think funding should also increase to get more psychiatrists?

Dr. SATEL. Of course.

Mr. MURPHY. And Dr. Parks, you already said so?

Dr. PARKS. The shortage is more severe for psychiatrists than the other categories.

Mr. MURPHY. Particularly child psychiatrists, I believe.

Dr. PARKS. Particularly child psychiatrists, horrible shortage.

Mr. MURPHY. I would just like to conclude with one other comment. When it comes to court-ordered inpatient or outpatient treatment, it is extremely important to note that unless a legal procedure takes place for inpatient or outpatient treatment by a court proceeding, that person's name does not go on the National Instant Background Check. Quite frankly, we don't know how many people should be on that list and the NICS list is what is used to determine if someone should be permitted to buy a gun. And while people are advocating whether or not we should expand registration, my concern is that we may not be putting people on that list who are at risk of abusing a weapon for an attack.

I yield now to Ms. DeGette for 5 minutes.

Ms. DEGETTE. Thank you, Mr. Chairman.

And Mr. Bruce, your experience is heartbreaking and as a mom, you know, I want to give my deepest condolences to you and all the issues that you continue to work through to this day. And I also want to say I think this assisted outpatient treatment should be a tool that psychiatrists and mental institutions are allowed to have. Forty-four States allow that right now.

And, Dr. Parks, maybe you can answer this. I think that in the block grants that SAMHSA gives to the States, they would be able to use that money for the assisted outpatient treatment if they decide to do that, correct?

Dr. PARKS. That is correct.

Ms. DEGETTE. Thank you.

Dr. PARKS. And to answer the chairman's question, I do not oppose assisted outpatient treatment——

Ms. DEGETTE. You don't oppose it either but——

Dr. PARKS. It is difficult.

Ms. DEGETTE. So in my previous life before I came to Congress I was a practicing lawyer, and I think everybody kind of alluded to this, including you, Mr. Bruce, which is if you are going to get in order for assisted outpatient treatment, that is going to have to be in order that is given by somebody. And I think maybe, Dr. Parks, that is what you are talking about when you talk about these mental health courts. Is that part of it?

Dr. PARKS. Assisted outpatient treatment is a civil court order and a mental health court is a criminal court order.

Ms. DEGETTE. OK. So this would be a——

Dr. PARKS. But either is a court order in either case.

Ms. DEGETTE. OK. But it is a court order. And so one thing I think—and this goes to our whole discussion we are having today—is that we have just woefully underfunded our entire mental health system in this country because if you are going to do a court order, which is appropriate in many cases, then you have to have the resources to enforce that.

And I have constituents coming in with very similar stories, Mr. Bruce, to yours. And, you know, one of the things we have learned in these hearings that we have been doing is that schizophrenia tends to manifest itself in young men between the ages of 19 and 25. So that is just the age that these young men are going off on their own. They are in college or whatever and they are above 18. And so, you know, the care providers of the colleges are not required to tell the parents. So this is the kind of tragedy we are hearing about and we don't have enough resources in our mental health system to target people like that and to help them.

Dr. Parks, you are nodding your head. Do you want to——

Dr. PARKS. Usually when I go to court to get either a civil order or to get a criminal condition of probation, it takes half a day. That means that there is 12 to 16 people I did not see in clinic because I was taking the time in court. Psychiatrists' time gets shorter and shorter and this is a choice agencies face. You know, I only have three——

Ms. DEGETTE. Right.

Dr. PARKS [continuing]. Psychiatrists. Do I do some more assisted outpatient treatment and tie up their time in testimony or do I try and just stay away from that?

Ms. DEGETTE. And there are not enough resources to process those cases and there is not enough resources to treat the patients. I had a lady in Denver who said to me that her son, he became psychotic. He was committed. Then, he was on a 72-hour hold. He was released and then he came home and he said, Mom, I think I am going to kill you or myself. And she couldn't get him the help he needed. And everybody has stories like this.

I just want to ask you a couple of questions, Dr. Parks, about the SAMHSA block grant program because a lot of people have been saying that a lot of SAMHSA's funding is not reaching people living with serious mental illness issues, and frankly, that is Congress' fault because of the way we budget it. But for the money that is used for mental illness as opposed to drug abuse, you have seen on the ground in Missouri funding from the SAMHSA Mental Health Block Grant. How much does Missouri get every year in that block grant?

Dr. PARKS. For the block grant we get approximately $7.5 million, a very moderate——

Ms. DEGETTE. And what percentage of the 7 ½ million that Missouri gets is used to treat people that don't have health insurance?

Dr. PARKS. About 65 percent goes to people that are uninsured.

Ms. DEGETTE. So if they didn't have that money from that block grant for mental health treatment, where would they be able to get mental health treatment dollars for your State?

Dr. PARKS. Where people usually go, the emergency room.

Ms. DEGETTE. OK. And how much of SAMHSA's Mental Health Block Grant is used to treat patients diagnosed with a serious mental illness?

Dr. PARKS. Essentially all of it. There is a small amount used for suicide prevention that was approved and there is about 4.5 percent we are allowed to spend on administrative overhead, much lower than the 20 percent administrative overhead that commercial insurance is allowed.

Ms. DEGETTE. So most of it is for serious mental illness? OK. Thank you very much, Mr. Chairman.

Mr. MURPHY. Thank you. I now recognize the gentleman from Texas, Mr. Olson, for 5 minutes.

Mr. OLSON. I thank the chair and welcome to our witnesses. A very special warm welcome to you, Mr. Bruce. I have seen a tragedy similar to yours. Two weeks before Christmas in 2003 a family of four from my church came home from dinner. A mass gunman was waiting for them. The wife was killed, the younger son was killed, the husband was severely wounded, and the oldest son was shot in the arm. The investigation took a course no one saw coming. Because of an irrational hate, the oldest son had hired a hitman to kill his family.

I know your situation is different from that situation, but having talked to the father, I know the courage it takes to come here and testify. So I thank you for your courage and your strength to be here today. You will be in my family's thoughts and prayers.

My question is for Mr. Torrey. Mr. Torrey, your first witness, you mentioned your 2010 request to SAMHSA for information, data on why federal costs in mental illness were increasing so rapidly and their response that there was no data. Have you received any information to your knowledge that SAMHSA has begun collecting this type of data? For example, in your testimony you said what if some States have more than three times more mentally ill individuals per population on SSI, supplemental security income, or on Social Security disability insurance than our States do? What is the percentage of mentally ill individuals on SSI, SSDI who are not receiving treatment? What is the percentage of Americans with serious mental illnesses who are receiving SSI and/or SSDI? And the answer you got? We have no data. Is that true?

Dr. TORREY. Yes, it is.

Mr. OLSON. There is no data?

Dr. TORREY. Yes, that is absolutely correct. And it is important to realize that we have $140 billion in the mental health treatment system right now. Everyone says we need more money. In fact, we have 12 times more, corrected for population, than we had 60 years ago. I am one of the few people in Washington who probably says we don't need more money; what we need to do is spend the money the way we should be spending it and focus on the seriously mentally ill. Then, we would have a system that worked.

Mr. OLSON. Can you identify any federal barriers as to why they are not collecting this data?

Dr. TORREY. I would say they are not collecting the data because they have no interest in these questions. And one of the things you will learn early in government is you don't ask questions that you don't want the answers to.

Mr. OLSON. This question is one for you again, Dr. Torrey, and Dr. Satel, if you would please answer this question as well. How can SAMHSA maximize their resources for those with severe mental illnesses? Just blanket. I mean how can they do this because they are missing the target completely? How can they maximize the resources right here, right now, today? Dr. Torrey?

Dr. TORREY. Well, there is a whole series of things they could do. First of all, you could look at the rate that Ms. Hyde talked about. Seventy percent goes to substance abuse, thirty percent to seriously mentally ill. I don't know why that ratio is as it is. It certainly should be at least 50/50 on it. Secondly, you can specify that SAMHSA must focus its resources on severe mental illness and report back on a regular basis. Third, I think a GAO investigation of the discretionary grants, things like the P and A program and other things is way overdue.

I have looked at a few of these grants under Freedom of Information. They really look like they need some light of day looking at them, and I think that is one of the important things the Committee could do.

Mr. OLSON. Thank you, Dr. Torrey. Dr. Satel?

Dr. SATEL. Yes. I would like to mention, though, that when we are all saying severe mental illness as a large category, and, yes, it typically refers to bipolar, schizophrenia, the chronic psychoses, but what we are specifically talking about is the subset of the severely mentally ill who are so psychotic that they don't know they are ill and can't cooperate. So even if a program says it is dedicated for the severely mentally ill, that doesn't really answer the whole question. It has to also respond to those who are so sick and so debilitated that they cannot cooperate with that program. That is an important difference.

But the more direct answer to your question, what I worry about in addition to what Dr. Torrey said is the active sabotage of the best interests of the mentally ill that SAMHSA underwrites. And again, the PAIMI, maybe if you kept the protection, I know they do some good things. I know there is certainly abuse in these institutions and someone needs to be a watchdog. The advocacy element has become very, very destructive.

Also, even though there is not much money, as Administrator Hyde had mentioned that may go to Alternatives Conferences or consumer survivor groups, that money is leveraged so efficiently, these folks go out and they lobby state legislatures and they interfere with the passage of these AOT laws. I mean they are very efficient. So even if it is a small amount of money, it can have a much broader effect than many might expect.

Mr. OLSON. Thank you, ma'am. I am out of time. I will remember the term "active sabotage." Thank you.

Mr. MURPHY. Thank you. I now recognize Mr. Griffith from Virginia for 5 minutes.

Mr. GRIFFITH. Thank you, Mr. Chairman. I appreciate all of you being here with your testimony and everything that you all have said. Great concerns about where we are spending our money and if we are spending it in the right places. I appreciate that, Dr. Torrey.

I will tell you that the court system is very concerned about this. I spent 27 years before I came to Congress 2½ years ago as a street lawyer as a lot of folks would say, dealt with families that were dealing with these issues, dealt with clients who were dealing with these issues. It is seen on a regular basis in every court across this country.

And I will do a little shout-out for my hometown. They don't call it a mental health court because that isn't authorized at this point, but one of our judges has set up a therapeutic docket specifically because we had sufficient numbers even in our area of people who are in the criminal court system who need help. And it may not be that they are completely out of touch like that subset you are talking about, Dr. Satel, the severe mental illness, but they have got significant issues that the court needs to make sure somebody is dealing with it. If our mental health system isn't going to do it, the court system has got to try to figure out how to do it in a just manner. And so I commend Judge Talevi for setting that up.

Mr. Bruce, in those regards, I would ask you what your son's condition was like before April 2006 and specifically if you could tell me, prior to killing his mother, had he had any contact with the criminal justice system?

Mr. BRUCE [continuing]. With the criminal justice system, but he had been brought to a hospital for evaluation in 2005 after pointing a loaded weapon at two people and coming within a hair of killing both of them. He was in a state of deep psychosis. At that time they decided not to send him to a commitment hearing after he had been on some Thorazine and a little bit of lithium and had calmed down because they said that he felt that he didn't meet the standard for involuntary commitment.

Mr. GRIFFITH. Who said that?

Mr. BRUCE. My wife and I waited in the psychiatrist's office for this commitment hearing to start. She got a call, said that was the hospital's lawyer and he felt that they didn't have a case so they weren't sending him to the commitment hearing. And I said what do you mean, no case? And she said, well, the standard is imminent danger, which actually is not the standard in Maine. It poses a likelihood of serious harm. But anyway, this is what happens when mental health people are forced to interpret law. I said, well, a couple weeks ago he almost killed two people. And she said, well, that was then and this is now. And I said, well, but you told me that in all likelihood the minute he leaves the hospital he is going to stop taking these medications which you yourself said are not even adequate for his disease. She said, how could I go before a judge and truthfully say that he was in imminent danger? Just look at him. I mean he was calm. He wasn't threatening anybody.

Mr. GRIFFITH. Well, what a tragedy and I am sorry for all the pain and the loss of your wife that you have had to go through over this.

Mr. BRUCE. Thank you.

Mr. GRIFFITH. Do you think at that time he was able to make decisions for himself that were rational?

Mr. BRUCE. No. No.

Mr. GRIFFITH. And you did obtain the guardianship in February 2007 and he was, I believe you said, found not guilty by reason of insanity, is that correct——

Mr. BRUCE. Yes, sir.

Mr. GRIFFITH [continuing]. At the time of the offense?

Mr. BRUCE. Yes.

Mr. GRIFFITH. OK. Well, I hope that we can find some answers and I appreciate all of you all testifying today.

I do think it is important that we have input at the court level because us street lawyers see a lot of mental illness in a lot of our clients and the family members know what is going on, so they need to be involved. And I have had many cases where the families kept folks from doing things that they might otherwise have done that could have caused problems. So I do appreciate it and appreciate all of your testimony today. Thank you.

I yield back, Mr. Chairman.

Mr. MURPHY. Thank you. The gentleman's time is expired. I now recognize that Dr. Cassidy of Louisiana for 5 minutes.

Mr. CASSIDY. Dr. Parks, for the record, obviously one of my concerns—I am a doc, too, not a psychiatrist—but one of my concerns is that some of the SAMHSA money is going for folks who advocate doing without medications. And yet I have read from your testimony it seems as if you would reject that. You firmly seem to believe that medications have a role in the treatment of serious mental illness.

Dr. PARKS. Absolutely. That is correct, Representative.

Mr. CASSIDY. Yes. I am told that you are a primary investigator or a principal investigator on a number of SAMHSA-type studies?

Dr. PARKS. That is correct.

Mr. CASSIDY. May I ask what type of studies just quickly?

Dr. PARKS. The two that I am currently principal investigator on, one is suicide prevention on the mental health side. This has been a 10-year series of grants, many of them are direct congressional funding. They said spend this on suicide prevention, particularly with youth, the Garrett Smith Act.

The second one is out of the CSA, the substance abuse side. And that is for a brief—that is for screening for excessive drinking and risky drug use with brief interventions following an assessment. It is a primary care intervention.

Mr. CASSIDY. I have just limited time so I get the——

Dr. PARKS. Sorry.

Mr. CASSIDY. Do you feel as if your participation in those grants presents a conflict of interest in your testimony today? Just asking.

Dr. PARKS. I agree it could have the appearance of that. I am here as an expert.

Mr. CASSIDY. I accept that. I mean I can make do. Do you agree with Dr. Satel and Dr. Satel's statement that it is not the actual severe, severe mental illness; it is the people with severe mental illness which is beyond the current reach of society that seems to be ignored by the funding priorities of SAMHSA?

Dr. PARKS. No, I would not agree by that. That is who we are spending the block grant money on and that is certainly who we were treating with the COSIG grants that have now ended. These are the grants that serve people that have substance abuse problems and serious mental illness, greatly increasing their risk of violence. So I would not agree.

Mr. CASSIDY. Dr. Satel, how would you——

Dr. SATEL. Yes, I would say that I have no question that Dr. Parks is treating people who have the diagnosis of schizophrenia and bipolar, and correctly so, but that they are not in that active phase where they are, again, so profoundly ill that they cannot even cooperate with your care.

So—but that is the point I am making, again, distinguishing between—the question isn't does SAMHSA have programs that serve people with these illnesses; it is, do they serve them also in the most debilitated phase of that condition?

Mr. CASSIDY. So I gather it was your testimony or Dr. Torrey's regarding now the efforts seem to be those patients who actually can participate in their care but the issue is how do we reach those who cannot participate in their care?

Dr. SATEL. Yes, exactly.

Mr. CASSIDY. OK. I got that. And you stand by your statement—you heard me quote your testimony earlier speaking to Administrator Hyde that there is a—I forget your term, but there is a relative imbalance in terms of the compendium of care?

Dr. SATEL. Oh, I definitely stand by that. I did clarify it when you, I think, were out of the room that I mentioned that there were only four studies that explicitly mentioned severe mental illness in their description, but, as you also alluded to, that there were more programs that probably did—or definitely did attend to them. But again, we are back to that distinction between those who can cooperate and those who can't.

Mr. CASSIDY. So, Dr. Parks, I respect that you are frontline. I mean I have worked in a safety net hospital so I always figure frontline folks have a little bit of street cred. My impression, though, is that SAMHSA has somewhat lack of focus. You heard my questioning of the administrator. Would you disagree with that or do you feel like everything is working great, no problem, or would you accept what Dr. Torrey says, what in the heck are we spending $20,000 on an oil painting for?

Dr. PARKS. I have not yet found a governmental agency that couldn't improve its performance.

Mr. CASSIDY. Were you at Charity, by the way, Charity Hospital?

Dr. PARKS. I was at a daughter of Charity.

Mr. CASSIDY. OK.

Dr. PARKS. I am a Charity alum.

Mr. CASSIDY. Yes.

Dr. PARKS. That is where I did my internship——

Mr. CASSIDY. Yes.

Dr. PARKS [continuing]. Wonderful experience. I think the major problem we have with SAMHSA is they are funding short. They cannot fund all their priorities adequately. In terms of the $20,000 painting, I can't support having funded that. That is $20,000 is very small dollars in the big picture of things. It is not an excuse to waste it but I think the proper policy focuses on the big picture dollars.

Mr. CASSIDY. And Dr. Torrey, I am sorry, I was out of the room with other responsibilities but is there anything that you would—you heard Administrator Hyde kind of contradict some of your assertions. Just now that I am back in the room, is there anything you would say to me as regards to her testimony?

Dr. TORREY. Yes, can you repeat that, Dr. Cassidy?

Mr. CASSIDY. Yes, her response to my questions in which I suggested that there was a lack of focus, she seemed to feel as if there is not. I take it you stand by your assertions that that indeed there is a lack of focus and even a frivolity as to some of their spending?

Dr. TORREY. Yes, it is not that there is no worthwhile programs. In SAMHSA there are some worthwhile programs but they are relatively few and far between. And I certainly stand by my statement that not only is severe mental illness not a priority; it is almost nonexistent.

Mr. CASSIDY. OK. I yield back. Thank you.

Mr. MURPHY. I thank the gentleman.

And I want to thank all the panelists today and all the members, both sides of the aisle. It is clear we are all dedicated to coming up with some answers, a solution. Unfortunately, it was pointed out this may not have the publicity of the IRS hearings or Benghazi, but given that 20 percent of people have diagnosable mental illnesses in any given year and 38,000 people commit suicide I think last year, 750,000 suicide attempts, we all are very concerned. And I appreciate the dedication of all the members of this committee in trying to find some answers.

I also want to restate my commitment and everyone's commitment to science-based evidence for real solutions. Good intentions do not guarantee good results, and as we move forward to come up with some solutions, I am pretty sure I speak for both sides of the aisle when I say that is what we are going to be looking for, good, effective results will do this.

Again, I thank everybody and I want to then mention that in conclusion I remind members they have 10 business days to submit questions for the record. I ask the witnesses to please respond promptly to any of the questions. Again, Mr. Bruce, our prayers and our thoughts are with you and your family and I thank all the other panelists for this very important hearing today

And with that, I adjourn.

[Whereupon, at 1:10 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

Index to Hearing Binder

1. 911 Transcript
2. Transcript of Hearing
3. Role of Patient Advocates
4. Chronology of Medical Records and Treatment for William Bruce
5. Preliminary Report as Guardian
6. Wall Street Journal Article
7. National Disability Rights Response to Wall Street Journal Article 1
8. National Disability Rights Response to Wall Street Journal Article 2
9. Letter from Nurse to Joe Bruce
10. Letter from William Bruce to Maine Legislature

THE WALL STREET JOURNAL.
WSJ.com

AUGUST 16, 2008, 12:21 P.M. ET

A Father's Call for Help

'My Son Has Killed My Wife'

Late one afternoon in June 2006, Joe Bruce of Caratunk, Maine, came home from work to find his wife dead. He called 911 and told the dispatcher that his 24-year-old schizophrenic son, William, had killed her, that he couldn't find the son, and that he was arming himself for self-defense. Below are excerpts from the transcript of that call made available to The Wall Street Journal. (See related article.)

* * *

Caratunk, Maine, June 20, 2006, at 4:49 p.m.

Dispatcher: 911. What is the address of the emergency?

Mr. Bruce: My name is [...] I live at [...] in Caratunk. Um, my son has killed my wife, he is schizo -- completely out of his mind.

Dispatcher: Where is your wife now?

Mr. Bruce: She is in the bathtub, she is dead. I just came home from work, her car is gone. [...] I don't believe anyone has been here, there is no sign the neighbors are aware of anything going on. His name [...]. He is 24 years old.

* * *

Dispatcher: How old is she?

Mr. Bruce: She's 48 years old. Please, please don't put this out over the scanner. Just send someone up somehow. Would you please just do me that favor?

Dispatcher: Hold on just one second sir, OK?

Mr. Bruce: Yes.

Dispatcher: OK, we are going to send them out over the phone that way....

Mr. Bruce: Yes, please. I will be right here. There's uh....

Dispatcher: Do you have any idea where your son may be going?

Mr. Bruce: I have have, he is completely out of his mind.

Dispatcher: OK, what is your phone number there?

Mr. Bruce: [*Number*]. I don't know where the phone went from up at the house, I'm down in her shop.

Dispatcher: OK. Stay right there, sir, I will be in touch with you shortly. I am going to make some calls and get everyone started that way, OK? Don't go anywhere.

Mr. Bruce: OK, yes. I will not.

Dispatcher: I'll call you back in a few minutes.

Mr. Bruce: Yes. Sir, I am going to arm myself. Please, I will only have a weapon nearby. I don't intend to kill him or anything, but if he shows up I do want to be able to defend myself. I don't want the officers to feel threatened when they get here. I won't be standing out there with a gun. I just wanted you to know that, OK?

Dispatcher: If you see a deputy or officer, just make sure you keep your hands where they can see them. I will inform them of that.

Mr. Bruce: OK.

Dispatcher: Just make sure if you see them you keep your hands where they can see them.

Mr. Bruce: OK.

Dispatcher: Somebody will be in touch with you shortly, sir.

Mr. Bruce: OK.

Dispatcher: Thank you.

* * *

[*The 911 Center called back.*]

Dispatcher: Did he have any access to weapons?

Mr. Bruce: I have... everything has been locked up for a long time.

Dispatcher: Do all of your firearms are locked up?

Mr. Bruce: Yes, I have a federal firearms license. Everything has been locked in a building in a safe with an alarm system. I have checked that.

Dispatcher: When was the last time you spoke to your wife?

Mr. Bruce: About 7 a.m. this morning.

Dispatcher: Was your son there at that time?

Mr. Bruce: My son was here -- he was asleep. We tried to get hold of the case manager. There's a guy they have, this, oh, this f--ing system. They let these people out. They won't give them medications and they let them out, and they put them with a case manager, I have called this guy. We said, "Jeez he is getting worse." I said, "I can't go on like this having him here, until he killed somebody."

Dispatcher: He has had some longer issues that go back?

Mr. Bruce: He got out of Riverview, they committed him and let him out, said there was nothing they could do for him, he won't take medication and they won't give it to him under this these f--ing nuts are the ones making these friggin, she was one of the most beautiful people in the world. [*Inaudible*]

Dispatcher: You have to stay with me.

Mr. Bruce: I know, I'm OK.

Dispatcher: We need to make sure we get everybody up there for you to make sure....

Dispatcher: I'm alright.

Dispatcher: OK. You are doing great.

Mr. Bruce: I'm alright. I'm, my other kids, the rest of the family, the lives that are going to be ruined because of the lunatic God D---laws. We told them he's going to kill somebody. They say, "Well he seems OK now so there is nothing that we can do, you know."

* * *

Dispatcher: You're the one there correct, sir?

Mr. Bruce: As far as I know. I don't know where he is.

Dispatcher: OK.

Mr. Bruce: But the car is gone.

Dispatcher: And that is your wife's car, correct?

Mr. Bruce: That is my wife's car.

Dispatcher: OK. There's a description showing on the Department of Motor Vehicles. We got the plate number and everything.

* * *

Dispatcher: Does he have any friends? Any idea at all where he might have gone?

Mr. Bruce: No clue. He has been completely out of his mind. He's been home here with us... I'm going to say three weeks, and he'll have periods where he'll calm down, but most of the time you talk to him and you can't even carry on a conversation with him. He talks about, way gone, way gone. Well, obviously.

Dispatcher: OK. I'm going to explain to you what we are doing on this end. Just so you know real quickly. I have an ambulance coming that way, but they are not going to be able to come there until the police secure that scene. OK?

Mr. Bruce: Yes.

Dispatcher: For their protection and your protection.

Mr. Bruce: Yes. I understand.

Dispatcher: OK. Police will come first. I've already told them you have a firearm to protect yourself. It's close to you and you don't have it on you. OK, when you see them....

Mr. Bruce: I know what to do. I will come out. They will know its me and not him.

Dispatcher: Right. They're going to go inside, probably just one of them.

Mr. Bruce: Which officers are coming up?

Dispatcher: I have numerous deputies coming.

Mr. Bruce: Alright. I know some of them.

Dispatcher: OK. [*Name*] is on his way. There's a list of them. Probably just one of them will go into the house and secure the scene.

Mr. Bruce: OK.

Dispatcher: And then the ambulance will go in, OK?

Mr. Bruce: I've been upstairs. The only place I haven't been down into the basement. I left my... I had no weapon, so I grabbed my flashlight when I went down to check the gun room, I grabbed my flashlight, that was the only light, but I'll....

Dispatcher: Do you have power there? There was a big storm going through.

Mr. Bruce: We lost power. I hit the worst of it in Solon, Bingham. It's just rain and a little lighter up here.

Dispatcher: OK.

Mr. Bruce: Oh God.

Dispatcher: You haven't called anyone to come down, have you?

Mr. Bruce: I haven't called anybody but you.

Dispatcher: OK. If you could refrain from doing that for right now.

Mr. Bruce: [*Inaudible*] Yes... just, I don't need all the, kinds of people getting wound up. We knew there was no plan and within a week he was back up here and we ... My wife wouldn't just leave him out. I said, "If he comes here something bad is going to happen." I knew it. I felt it.

* * *

Dispatcher: OK. They are actually coming towards you. I just want to make sure that they are going to get there. OK, as soon as they get there we can hang up.

Mr. Bruce: Yup.

Dispatcher: You're on the front porch now?

Mr. Bruce: I am on the front porch now.

Dispatcher: OK. Just so they can identify you sir, what are you wearing?

Mr. Bruce: Blue jeans, black and white checked shirt, sleeves rolled up, blue baseball cap on.

Dispatcher: OK.

Mr. Bruce: I'm 54 years old [...] I have the shot gun sitting on the kitchen table. I don't know where he is.

Dispatcher: OK.

Mr. Bruce: When they come, I'm watching, I'll go out the door. There's nothing to worry about. I understand how it works.

Dispatcher: OK.

Mr. Bruce: There's not going to be a problem. You don't have to worry about it. I'm not going to do anything stupid.

Dispatcher: Please, don't walk around much sir.

Mr. Bruce: I am sure you have already put out an APB, or whatever you guys call it. I just want to let them know they want to be God D--- careful approaching him because he is completely out of his mind.

Dispatcher: OK.

Mr. Bruce: And he was in the army and he does know how to kill.

Dispatcher: He does, OK. So he would be considered armed and dangerous.

Mr. Bruce: He must be. I don't know what he is armed with. I don't know what he is armed with. I've got to say it's a knife of some sort.

* * *

Dispatcher: So, is it still raining up there?

Mr. Bruce: Yeah, but not hard.

Dispatcher: Does your wife work, sir?

Mr. Bruce: Yeah, home business.

Dispatcher: And your son, does he work?

Mr. Bruce: My son does not do anything. He is totally incapable of functioning.

Dispatcher: OK. Was he on any medications, I know you said he refused?

Mr. Bruce: No.

Dispatcher: OK. Does he have a diagnosis?

Mr. Bruce: Yes.

Dispatcher: Do you know what that is?

Mr. Bruce: Yes, schizophrenia. [*Inaudible*]

Dispatcher: What was that?

Mr. Bruce: I haven't checked out the barn yet.

Dispatcher: OK. Don't go in there then.

Mr. Bruce: OK.

Dispatcher: Hang on a second. I am going to ask them how long it is before they get there.

Mr. Bruce: OK.

Dispatcher: They are about four minutes out.

Mr. Bruce: Yup.

Dispatcher: Think you can take talking to me for another four minutes.

Mr. Bruce: Still hanging in there.

Dispatcher: Alright. Good deal. When you called me today, sir, you had just arrived home from work?

Mr. Bruce: Yes. I work for [...]. I just left the Fairfield office, stopped at Dr. ------ office to pick up a prescription and didn't stop for gas.....

Dispatcher: Is there something else?

Mr. Bruce: No.

Dispatcher: Just trying to see if you knew what he was wearing when you left for work or was he still sleeping so you wouldn't know that.

Mr. Bruce: I have no idea what he was wearing.

Dispatcher: OK.

Mr. Bruce: He's got... I believe it's... [*Inaudible*]

Dispatcher: Have you been fighting lately? I'm sure it is hard to live with someone with that diagnosis. Do you know if they were fighting?

Mr. Bruce: No.

Dispatcher: OK.

Mr. Bruce: No, he was really whacked out the last couple of days. We talked about it last night. I said, "He's getting worse, more aggressive." I called this guy named [*Name*] who is the case manager three times trying to get hold of him.

Dispatcher: Are you south of the Pleasant Pond turnoff, sir?

Mr. Bruce: [*Directions*]. As soon as I see a cruiser I'll be right out the door.

Dispatcher: OK. He is on the road now, just looking for your place.

Mr. Bruce: Yup, I'll stand out on the porch.

Dispatcher: OK. You can see the porch from the road?

Mr. Bruce: Yup.

Dispatcher: They're there sir?

Mr. Bruce: No.

Dispatcher: He's asking if you are north of the Village.

Mr. Bruce: I'm in the Village, [*Directions*]. I'll be standing out in the driveway.

Dispatcher: OK.

Mr. Bruce: I see him right now.

Dispatcher: Is he there with you?

Mr. Bruce: He is coming, they're pulling in now, two of them.

Dispatcher: You got them?

Mr. Bruce: Yes.

Dispatcher: OK. Thank you, sir.

Mr. Bruce: Good bye.

* * *

Police arrested William at his grandparents' house, 120 miles away in Portland, Maine, and charged him with his mother's murder. William was eventually found not criminally responsible by reason of insanity for the crime and was sent for treatment at Riverview Psychiatric Center, in Augusta, Maine, the same hospital that had released him shortly before the murder. He will be there indefinitely.

STATE OF MAINE

PENOBSCOT, ss.

SUPERIOR COURT
Criminal Action
Somerset Docket No. CR-06-298

STATE OF MAINE)
)
v.)
)
WILLAM BRUCE,)
)
Defendant.)

COPY

ARRAIGNMENT & HEARING

BEFORE: HONORABLE JOSEPH M. JABAR,
JUSTICE OF THE SUPERIOR COURT

Penobscot County Courthouse
97 Hammond Street
Bangor, Maine

March 27, 2007

APPEARANCES:

For the State:	ANDREW B. BENSON, ESQ.
For the Defendant:	PHILIP G. MOHLAR, ESQ.

Maureen A. Bradford
Official Court Reporter

INDEX OF TESTIMONY

* * * * *

INDEX OF EXHIBITS

State's Exhibit No.	Description	Offered	Admitted
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* * * * *

TRANSCRIPT OF PROCEEDINGS

(This case came on for hearing before Honorable Joseph M. Jabar, Justice, at the Penobscot County Courthouse, Bangor, Maine, on March 27, 2007, commencing at 9:10 a.m.)

* * * * *

THE COURT: You may be seated. Good morning everybody.

Okay. We're on the record. First of all, I want to thank you for coming here. We couldn't find a courtroom in Somerset County, so I appreciate your traveling up here to take care of this. This is State of Maine versus William Bruce, Docket No. CR-06-298.

Are you William Bruce?

THE DEFENDANT: Yes, Your Honor.

THE COURT: Okay. Mr. Bruce is in the courtroom with his attorney, Mr. Mohlar. I understand that Mr. Bruce has not entered a plea yet -- has not been arraigned on the charges, is that correct, gentlemen?

MR. MOHLAR: That is correct, Your Honor. There's issues of competency, and so he has not yet been arraigned.

THE COURT: Okay. So one of the first issues

(The witness left the witness stand.)

MR. BENSON: I call Dr. Diane Schetky.

THE CLERK: Please raise your right hand and state your name for the record.

THE WITNESS: Diane Schetky. S-c-h-e-t-k-y.

THE CLERK: Thank you. Do you solemnly swear or affirm the testimony you will give in the cause now in hearing will be the truth, the whole truth, and nothing but the truth, so help you God.

THE WITNESS: I do.

THE CLERK: Please be seated.

DIANE SCHETKY, having been duly sworn, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. BENSON:

Q. Good morning, Dr. Schetky.

A. Good morning, Mr. Benson.

Q. Your name is Diane Schetky?

A. It is.

Q. And you're a physician licensed to practice in the state of Maine?

A. I am.

Q. And in addition to being a physician, you're a psychiatrist?

A. That's correct.

Q. And, sadly, you are about to retire from consulting for the State Forensic Service; is that right?

A. That's true.

Q. Formerly, or at least currently up until a few months from now, you did the bulk of the psychiatric work for the State Forensic Service; is that fair to say?

A. I guess so. I don't know the actual numbers.

Q. I can't think of anybody else.

A. But there are many more psychologists working for the service than there are psychiatrists, and I guess I've kind of specialized in the northern part of the state, which I'm told starts in Falmouth.

Q. Augusta. Dr. Schetky, prior to your retirement, the last couple of years, did you limit your practice almost solely to the area of forensic psychiatry?

A. That is true, since 2000. And, then, about a year and a half ago, I eliminated the private practice, and I've only been working part-time for the State Forensic Service.

Q. And could you describe briefly what forensic psychiatry is? It's probably largely similar to forensic psychology, I assume.

A. It is, very similar. It's the application of psychiatric expertise to legal issues. Our role is not to help the examinee but, rather, to help the Court weigh the mental health issues as they might impact on the legal questions.

Q. And, briefly, Dr. Schetky, can you describe your educational background?

A. Yes. I graduated from Sarah Lawrence College. I then went on to Case Western Reserve University School of Medicine in Cleveland. I graduated from there in 1966. I did a year of an internship in pediatrics. I then did a residency in adult psychiatry and another residency in child psychiatry.

Q. And could you describe just generally in a post-education sense your experience in the field of clinical psychiatry?

A. Yes. Until 2000, I maintained a private practice, which consisted of both children and adults and adolescents.

Q. And clinical psychiatry is what as opposed to forensic psychiatry?

A. The diagnosis and treatment of mental illnesses, as well as providing consultation to physicians and other mental health personnel. But throughout that time, I also did forensic psychiatry, initially in the arena of child and adolescent forensic psychiatry. Then branched out into doing civil cases involving adults and children, and, then, since '98, was seeing criminal defendants for the State Forensic Service, as well as doing civil cases.

Q. And you've done forensic psychiatry not just in the state of Maine; is that fair to say?

A. Oh, I got started way back in Oregon in the 1970s writing about child sexual abuse.

Q. Now, can you also describe, Dr. Schetky, the experience that you've had in terms of identifying major mental illness?

A. Well, certainly that was a major part of my psychiatric education, my residency training, and I've continued to focus on that area throughout my years of private practice.

Q. And could you describe, again, for purposes of the record, what major mental illness is?

A. Yes. Generally, as Dr. Wisch said, it consists of psychiatric disorders that are often accompanied by impaired reality testing such as mania or the spectrum of schizophrenic disorders. Major mental illness can also be a result of severe traumatic brain injury. But, generally, there's a high degree of impairment there, and, for legal purposes, that impairment would impact on their ability to appreciate the wrongfulness of their behavior.

Q. And I know you've touched on this briefly in your answer, but does major mental illness also frequently involve psychosis?

A. Yes.

Q. And could you describe what psychosis is?

A. Yes. As Dr. Wisch said, it's impairment of reality testing involving both cognition and perception.

Q. And throughout your career, how many times, approximately, if you know, have you had occasion to testify as an expert witness on forensic matters in court?

A. Probably over 200.

Q. Now, I'd like to call your attention to late last summer, early last fall. Did you have occasion to receive a Title 15 order to evaluate Mr. Bruce, the defendant in this case?

A. Yes, I did.

Q. And did you begin, as Dr. Wisch said he began, in terms of sort of dealing with the issues surrounding the issue of competence?

A. Well, I -- I usually begin with getting informed consent to proceed.

Q. Probably a good way to start.

A. So Mr. Bruce was clear about my role and who I was or was not working for.

Q. So --

A. And the implications of following through with the investigation.

Q. You weren't there to treat him --

A. Exactly.

Q. -- but to provide information to the Court?

A. Exactly, and that I could be called upon to testify.

Q. Now, in preparing for your evaluation of Mr. Bruce, did you have occasion to read the police reports in connection with this case?

A. I did.

Q. And did you also read the Acadia records and the Riverview records in connection with the case?

A. I did. I think there was about 600 pages of discovery.

Q. And there was also another forensic psychologist, a University of Maine professor, Jeffrey Hecker, who also did an initial evaluation of Mr. Bruce; is that correct?

A. Yes, he did, yes.

Q. And did you have occasion -- did you have access to Dr. Hecker's report?

A. I did review that.

Q. And would it be fair to say, Dr. Schetky, that when you dealt with Mr. Bruce initially, it became clear to you right from the outset that there were concerns concerning whether he had the skills associated with competence?

A. Yes, particularly in the area of his ability to work with his attorney. His thoughts were so scattered and fragmented and delusional, I thought he would have trouble tracking procedures. I thought he would have trouble probably retaining new information because there was so much going on on his radar screen, clutter in his mind.

Q. When you say there's so much going on there, you're referring to psychotic delusions and hallucinations?

A. A lot of paranoid thoughts, as well as grandiose thoughts, that impaired his reasoning. If I could give an example, he had this fantasy that somehow he was going to defect to Russia and the KGB wanted him to work for them. And in my initial evaluation, I had a resident sitting in with me who happened to be Russian, and he was so pleased when he figured out that she was from Russia, and he assumed that she had come over there -- come over here just to meet with him and that she was going to assure his safe passage -- passage somehow back to Russia, and we had to spend a lot of time clarifying that was not her role. So, as you can see, he was perceiving a lot of things through that very paranoid lens, attaching special meaning to things.

Q. And sometime toward the end of summer or early fall, you wrote an initial report to the Court concerning Mr. Bruce; is that correct?

A. I did, yes.

Q. And in that report, do you essentially say that you had concerns concerning competence and that you really couldn't reach the other issues because you couldn't get beyond competence?

A. That's true.

Q. And as a result of that report, there was an initial finding that Mr. Bruce lacked the skills associated with competence?

A. Correct.

Q. Is that your understanding? Now, Mr. Bruce, after that, went back to Riverview; is that correct?

A. He was at Riverview when I saw him.

Q. All right. So he was treated at Riverview during the fall and early winter of last year, going into this year?

A. Well, it was more custodial care initially because he was refusing antipsychotic medication, which would have been the first line of treatment.

Q. Now, at some point, did Mr. Bruce begin to agree to take the antipsychotic medication?

A. He did, in December.

Q. And did that cause a change in terms of his having the skills associated with competence?

A. Indeed it did.

Q. And could you describe that?

A. Yes. His -- his thoughts were much more organized. I found he still had some residual -- residual paranoid thoughts.

Q. Mm-hmm.

A. The other remarkable change was he was starting to have some insight into the fact that he had a mental illness and perhaps he really did need to be on medication. That was totally lacking when I first saw him. So he was -- his reality testing was much improved. He appreciated the severity of this crime, even evidenced some remorse, and I felt at this point he was capable of working with

Mr. Mohlar.

Q. You --

A. But I put in the proviso there that it was very important that he stay on his antipsychotic medication.

Q. And would it be fair to say that you still believe that in spite of some of this paranoid thinking, that by and large he has the skills associated with competence?

A. I believe he does.

Q. Now, when Mr. Bruce began taking the antipsychotic medication that you referred to, were you able to go back to him and then look into the issues of criminal responsibility?

A. Yes, I was.

Q. And did you take a history from Mr. Bruce at that point about the events of June 20th?

A. I did.

Q. And could you briefly relate to the Court the history that you took from Mr. Bruce?

A. Yes. He told me how he had left Riverview Psychiatric Center the end of April. He was not taking any medication because he didn't like the side effects. He realized that his condition was getting worse, although he was not conflicted

The Role of the Patient Advocates:
A Summary of the Medical Records of William Bruce

By March 2006, William Bruce had a well documented history of dangerousness, paranoid thinking, and refusal to take medication. Despite this, and despite his family's oft-voiced fears for his and their safety and their pleas that he remain in an environment where he would be compelled to take the medications that were so effective in ameliorating his condition, the patient advocates from the Disability Rights Center ("DRC") persistently lobbied William's doctors to allow William to leave Riverview. William was discharged from Riverview Psychiatric Center on April 20, 2006. He murdered his mother on June 20, 2006. The following is a brief summary of events leading up to his discharge, with an emphasis on the role that the patient advocates played in this tragedy.

On March 23, 2006, William met with his treatment team, including his psychiatrist Dr. Fliesser. The "patient advocates" Helen Bailey and Trish Callahan from the DRC were also present at this meeting. Members of William's family were excluded and were not present. Dr. Fliesser's notes indicate that during the meeting "repeatedly emphasized to the disability rights advocate my clinical opinion that the patient's paranoid psychosis is not likely to improve without pharmacotherapy" and "the patient continues to refuse pharmacotherapy." Fliesser's notes make clear that the patient advocates disregarded his cautions. The notes reveal that the advocates instead asked for clarification of specific treatment goals for him so he could be released from the hospital. Ms. Bailey, not a doctor herself, even asked if a second opinion from another psychiatrist could be obtained. (Tab 15[1]: Note by Jeffrey M. Fliesser MD, dated 3/23/06).

Helen Bailey stated that she had reviewed the medical record (!) and saw no documentation to support William's having to remain at Riverview. (Tab 16: Progress Note from the Treatment team meeting, dated 3/23/06). Patient advocate Callahan suggested that William may actually be getting worse by remaining at Riverview. (Tab 16: Progress Note from the Treatment team meeting, dated 3/23/06). On March 27, 2006, Dr. Fliesser's notes again indicate that he "emphasized" to both William and William's "advocates" that William requires pharmacotherapy to treat these paranoid symptoms and be able to be safely discharged to the community and William continues to refuse medication. (Tab 19: Progress Note by Jeffrey M. Fliesser, MD, dated 3/27/06). His views mirrored that of the people who knew William best, his family.

After Dr. Fliesser stopped seeing William on March 30, 2006, the patient advocates began to urge William's new psychiatrist, Dr. Filene, to discharge William. At a treatment team meeting on April 6, 2006, social worker Andy Davis and patient advocate Trish Callahan were present. During the meeting, the notes reveal that Callahan actually instructed William how to answer, as if she were his lawyer at a deposition or trial, and repeatedly interjected on his behalf, as Dr. Filene was attempting to examine him. William deferred to Callahan and was much less interactive than in a meeting with Dr. Filene on the previous day, when, notably, the patient

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[1] References to "Tab __" are to the medical records found behind the referenced tab in an accompanying notebook.

advocates were not present. Callahan redirected the discussion away from exploring William's history, mental status and treatment, and focused the discussion instead on attempting to define a date of discharge and her own assertions that William's well-being was being harmed by ongoing hospitalization. She stated the prospects of his summer employment would be impaired the longer he stays. The meeting had a tone of "legal antagonism" according to Dr. Filene's contemporaneous notes. (Tab 23: Progress Note by Daniel R. Filene, MD, dated 4/6/06).

When Dr. Filene asked William about his activity level being increased so he could access the community he hesitated. Again according to Dr. Filene's contemporaneous notes: "Ms. Callahan then stated, 'They want to see that you can play nicely in the community. Just say yes,' after which William Bruce stated 'Yes.'" The doctor asked William whether there was any risk he'd refuse to return to the hospital from a community trip; according to the medical records, "Ms. Callahan told him 'Just say no,' after which William stated 'No.'" (Tab 23: Progress Note by Daniel R. Filene, MD, dated 4/6/06)

When Dr. Filene asked William about speaking with outpatient providers, Ms. Callahan responded that there would be no benefit in obtaining their opinions and William declined consent. When Dr. Filene asked if he could speak with William's mother, Ms. Callahan responded that his parents are a negative influence in his life (!) and William declined consent. William said he would not undertake psychological testing with a Dr. Gregor. When Dr. Filene inquired about his misgivings, "Ms. Callahan responded 'He said no, he doesn't have to answer anything else.'" William was innately guarded about his mental state, and was "further urged in this direction by his advocate who urges him to avoid revealing personal information." "The opinions of those who know him best in the community [referring to William's family and others] are not available to me, again with the advocate's concurrence." (Tab 23: Progress Note by Daniel R. Filene, MD, dated 4/6/06)

On April 11, 2006, William told Dr. Filene that his advocates are stating "he is not ill, not a danger and should be released." (Tab 24: Progress Note by Daniel R. Filene, MD, dated 4/11/06). On April 20, 2006, Dr. Filene noted that "Mr. Bruce and Patient Advocates continue to push for his release" in advance of the expiration of his court commitment. The Client, social worker, and Advocate continued to reiterate that William had a secure discharge plan including housing with his friend Jesse. Dr. Filene then began discussing a plan of discharging William on April 24 but this date did not work for social worker Andy Davis for his own personal reasons, who requested it be moved to April 20. Dr. Filene agreed to the advancement. (Tab 26: Progress Note by Daniel R. Filene, MD, dated 4/20/06).

After discussing this plan with William, Dr. Filene was informed that Jesse was out of state until early May but Andy Davis arranged for William to stay at a hotel *by himself* until Jesse returned. Dr. Filene noted that "he weighed the potential increased risk of social isolation while using a hotel, against the importance of promoting the patient's trust in the mental health system by not reversing my agreement to discharge." At the team meeting Dr. Filene discussed the plan with social worker Davis who was comfortable with it and indicated he was nearby and could check on William frequently. (Tab 26: Progress Note by Daniel R. Filene, MD, dated 4/20/06). William was discharged on April 20, 2006.

The patient advocates repeatedly encouraged Dr. Filene to discharge William. Even though Dr. Filene's progress notes on April 6 and April 11 stated that Dr. Filene felt "Mr. Bruce presents an intermediate level of safety concern," the patient was discharged on April 20. (Tabs 23 and 24: Progress notes by Daniel R. Filene, MD, dated 4/6/06 and 4/11/06 2006).

William Bruce:
Chronology of His Diagnosis and Treatment

2/06/06 – William Bruce is admitted to Riverview Psychiatric Center; initial nursing assessment states "poor impulse control", "delusions", "agitation", "noncompliance with meds", "isolative", "guarded", "assaultive." (Tab 1- Initial Nursing Assessment signed by RN Cecelia Garrett, see page 10, pages 1-5 are missing from our folders)

2/06/06 – "Pt has paranoid ideations w/ delusional thought process. Pt is on an involuntary 90 day court commitment." "Patient lacks ability to control impulses." "Patient is threatening and assaultive." (Tab 2 - Admission Note signed by RN Cecelia Garrett)

2/10/2006 – "Due to recent violence associated with current hospitalization, Mr. Bruce continues to meet medical necessity criteria." He is refusing to take medication. "Observation in a secure setting is crucial at this time" for this patient who has a history of violent potential. "Schizoaffective disorder, bipolar-type, alcohol and polysubstance abuse (marijuana and cocaine)." No overt threatening behavior. (Tab 3 - Progress Note signed by Jeffrey M. Fliesser, MD, the patient's psychiatrist)

2/14/06 – "[D]angerous to others if discharged to a less restrictive setting at this time." William has a history of recent violence and "he continues to have some evidence of paranoid thinking on mental status examination." Not a management problem so far but his mental status examination notes show he has "ongoing paranoid thinking." William insisted people made things up about his history, including the treatment team at the hospital from which he was transferred to Riverview. This in conjunction with his recent history of violence against his father "continues to make him dangerous to others." He has no insight into his illness and refuses medication. (Tab 4 - Progress Note signed by Jeffrey M. Fliesser, MD)

2/23/06 – "Due to ongoing paranoid symptoms, and the patient's recent history of violence towards his father, he is dangerous to others without additional observation, and active attempts to treat him." William suffers from paranoid schizophrenia and remains guarded, often hostile and has no insight into his mental illness. When Dr. Fliesser tried to supportively confront him with the symptoms he called him an "Asshole." "Although he has not had behavioral problems on the unit so far, he has a serious history of violence and ongoing paranoid symptoms and marked guardedness." (Tab 5 - Progress note by Jeffrey M. Fliesser, MD)

3/01/06 – William continues to have no insight into his illness, resists taking any medication, but is observed with paranoid symptoms and some threatening behavior at times. For example, he was observed whispering to another patient "What would happen if I punched you in the head." While there have been no overt acts of aggression observed on the unit so far, these threatening statements "in the context of some paranoid symptoms and his recent history of violence prior to admission, make him dangerous to others without additional observation and treatment." (Tab 6 - Progress Note by Jeffrey M. Fliesser, MD)

3/07/06 – Dr. Fliesser "strongly encourages" William to consider taking medication to feel more comfortable around others and diminish his paranoid thinking. "It is my clinical opinion that without such treatment, he would remain dangerous to others if released to the community without treatment." "Mr. Bruce continues to have paranoid symptoms evident, and is refusing pharmacotherapy at this time." He continues to be "markedly guarded." He denies having pointed a loaded AK47 at two of his friends when target practicing even though there is documentation this incident did occur. William misattributes hostile intentions to doctors, his parents and anyone who has reported he had symptoms of mental illness. This is consistent with paranoid schizophrenia. (Tab 7 - Progress Note by Jeffrey M. Fliesser, MD)

3/13/06 – William was caught smoking in the bathroom today and he apologized. William is pleasant on approach. (Tab 8 - RN Note signed by RN Cecelia Garrett)

3/14/06 – William said "he'd like to get out of here but somebody has it in for me." He was assured by a MHW that if he kept up his good behavior he would be able to leave soon. (Tab 9 - MHW Note signed by MHW whose name appears to be Judy Ferris and a RN whose name is illegible)

3/14/06 – "Due to ongoing paranoid symptoms, evident on recent mental status examinations coupled with the patient's poor insight into his mental illness and with a history of dangerousness in the context of his mental illness, the patient remains dangerous to others without treatment." William declined to speak to Fliesser on this day. Another patient told Dr. Fliesser that William made an obscene gesture towards him as Dr. Fliesser was talking with that patient. (Tab 10 - Progress report by Jeffrey M. Fliesser, MD)

3/17/06 – William is quiet and visible on the unit, and is sociable with select peers. He said that he has yet to get free time "because he refuses to take meds," and he says "There's a law that says I don't have to take meds." (Tab 11 - RN Note, appears to be signed by Valerie Files)

3/18/06 – William continues to harass clients for cigarettes. William denies taking a cigarette but he was observed doing so by two MHWS and when approached to return the cigarette he said "whatever and gave the middle finger repeatedly." (Tab 12 - Progress Note, note type is labeled nursing but signature is illegible)

3/19/06 – Mood is okay but his "delusional material comes out." William said he is of Scottish descent and his great ancestors were royalty and he wants to be called 'Wilhelm'. (Tab 13 - RN Note, signature illegible)

3/20/06 – "Due to ongoing paranoid symptoms, history of dangerousness in the context of symptoms of his mental illness, the patient's lack of insight into his illness and unwillingness to take any medication treatment for it, he remains dangerous to others if released without additional treatment and stabilization from the hospital." William has ongoing paranoid symptoms of hostility, making obscene gestures, cursing at Fliesser and displaying hostility and other paranoid symptoms to the staff. Pharmacotherapy is crucial to ameliorate paranoid symptoms. William is "dangerous indeed for release to the community without pharmacotherapy and decrease in paranoid symptoms." (Tab 14 - Progress Report by Jeffrey M. Fliesser, MD, pages 1-2)

William hid silverware and was seen speaking to another patient who has a history of self injury and secreting dangerous items on the unit just before this missing silverware incident. William said he innocently placed them in his pocket and forget they were there. Dr. Fliesser was of the impression that William was attempting to conceal the utensils but not attempting to use them as a weapon. (Tab 14 - Progress Report by Jeffrey M. Fliesser, MD, pages 2-3)

3/23/06 – William was seen today by Dr. Fliesser along with his advocate Helen Bailey and his disability rights advocate Trish, his community case manager, and the regular treatment team. Dr. William Nelson, the medical director, was also present. Fliesser's note states "I repeatedly emphasized to the disability rights advocate my clinical opinion that the patient's paranoid psychosis is not likely to improve without pharmacotherapy. Nonetheless, William continues to refuse pharmacotherapy and, in my clinical opinion, at this time remains competent to give or refuse informed consent." (Tab 15 - Incidental Note by Jeffrey M. Fliesser, MD)

William has an emergence of paranoid symptoms including hostility, cursing at staff, accusing staff of stealing from him, accusing Dr. Fliesser of being jealous of him and reportedly harassing clients for cigarettes. Advocates asked for explanation of his treatment program to secure his release. Ms. Bailey asked if a second opinion from another psychiatrist could be obtained. Dr. Nelson is considering this but pointed out the patient will get a second opinion because Dr. Fliesser is leaving and Dr. Daniel Filene will take over. (Tab 15 - Incidental Note by Jeffrey M. Fliesser, MD)

3/23/06 – Helen Bailey verbalized concern that she reviewed the record and saw no documentation to support William having to remain at Riverview. Patient advocate Callahan suggested that William may actually be getting worse by remaining at Riverview. (Tab 16 - Progress Note from the Treatment Team Meeting, note type is nursing, appears to be signed by Colleen Cutler)

3/24/06 – When asked if he would like lunch William stuck up his middle finger. William looked at a MHW and said "I've got your number." (Tab 17 - Progress Notes signed by MHWs, signatures are illegible)

3/25/06 – William said "I'm just going to do my time here, until my commitment is up, not taking meds." He states he "only has a few more weeks before his discharge." (Tab 18 - RN Note, appears to be signed by Valerie Files)

3/27/06 – Dr. Nelson examined William at Dr. Fliesser's request in order to "ensure continuity of care" when Dr. Daniel Filene takes over. William refused evaluation by Dr. Fliesser but agreed to speak with Dr. Nelson on an individual basis. According to Fliesser's progress note, the treatment team reports "that the patient has continued to exhibit paranoid and hostile behaviors," including sticking up his middle finger at a mental health worker and telling another staff member "I got your number." (Tab 19 - Progress Note by Jeffrey M. Fliesser, MD, page 1)

Fliesser's progress note states that in light of ongoing paranoid symptoms, which include suspiciousness, guardedness and evasiveness on questioning, hostility towards the staff (as evidenced by making obscene gestures, telling the staff, for example, "I got your number"), and delusional beliefs that Dr. Fliesser and a number of other people are lying, "<u>I believe he remains</u>

dangerous if released to the community without pharmacological treatment of these paranoid symptoms." (Tab 19 - Progress Note by Jeffrey M. Fliesser, MD, page 2)

Dr. Fliesser stated in his notes that he "emphasized" to both William and William's advocates that William requires pharmacotherapy to treat these paranoid symptoms and be able to be safely discharged to the community. William continues to refuse to take medication. William's worrisome violent history (pointing a loaded AK47 at two of his friends as well as a physical altercation with his father) in conjunction with paranoid symptoms, "makes him a serious risk to harm himself if released to the community." (Tab 19 - Progress Note by Jeffrey M. Fliesser, MD, page 2)

3/30/06 – Psychologist notes that "William remains guarded and suspicious." She spoke to him about how suspiciousness/lack of trust hinders self-disclosure and mentioned her understanding of his eagerness to leave and reluctance to disclose information he believes may interfere with getting out of the hospital. William said he viewed the therapist client relationship as predator-prey. (Tab 20 - Progress Note by psychologist, appears to be signed by Janie, last name illegible)

3/30/06 – Dr. reviewed William's prior records from Acadia Hospital related to the patient's admission there on March 27, 2005 and summarizes certain sections in this incidental note. The Dr. noted that when he reviewed the records he saw "striking similarities in the patient's presentation then as well as the attending psychiatrist's great concern about the patient's dangerousness." Dr. said "I am in clear concurrence" with the other psychiatrists who treated the patient at Acadia Hospital "in that the patient is presenting now with very similar symptoms, and I agree that he is at high risk of being released to the community if he does not receive pharmacotherapy to ameliorate his paranoid and other psychotic symptoms." (Apparent typo here Dr. must mean to say he is at high risk if released to the community) (Tab 21 - Incidental Note Signed by "William Nelson, MD for Jeffrey M. Fliesser, MD")

Dr. Fliesser stops seeing William on March 30th 2006

4/5/06 – William told his psychologist he is a distant relative of President Bush and the psychologist noted that when he mentions subjects typically kept concealed he becomes guarded about discussing the topic further. (Tab 22 - Progress Note by psychologist, appears to be signed by Janie, last name illegible)

4/6/06 – Dr. Filene's notes begin. William's "case currently is in a high state of contention." William will not allow contact with his parents or others in the community who might know him well. William says he will decline appointments to see a psychiatrist in the community. While at Riverview, William has reportedly had no serious, overt acts of aggression but there have been a variety of instances which, taken together, may be worrisome. For example, instances documented in the record include frightening staff by putting his arm around them; attempting to bring contraband metal objects back to the unit; making threatening statements toward peers (on 4/3 he was reported to have told a peer he would put a pillow over his face). (Tab 23 - Progress Note by Daniel R. Filene, MD, page 1)

Dr. Filene's progress note mentions that Dr. Fliesser's notes indicate patient "has a serious but subtle, psychotic disorder, which he often effectively masks" and Fliesser made repeated notation that he believes William "poses a serious danger of violence to himself and others." Dr. Filene states that Dr. Nelson believed William has a "significant psychotic illness and may be at some risk for adverse event if discharged" but "he feels the risk is somewhat lower than Dr. Fliesser's assessment." Dr. Filene states that Dr. Gregor, unit psychologist, reports that William has "notable paranoid and disorganized features, but was uncertain whether these represented short-term dangerousness." Many of the nursing staff think he should be discharged. Review of past records in the chart shows assessment by two psychiatrists at Acadia both of whom felt that "Mr. B represented a serious, though subtle, danger if symptoms remain untreated." Disability Rights Center is assisting patient. (Tab 23 - Progress Note by Daniel R. Filene, MD, pages 1-2)

At Treatment Team Meeting on 4/6 patient was joined by his ICM, Andy Davis and Patient Advocate, Trish Callahan. Callahan instructed William in the meeting and repeatedly interjected on behalf of him. William deferred to Callahan and was much less interactive than on the previous day. Callahan focused on attempting to define a date of discharge. She redirected the discussion away from exploring William's mental status and treatment. She stated the prospects of his summer employment would be impaired the longer he stays. Meeting had a tone of "legal antagonism." When Dr. Filene asked William about his activity level being increased so he could access the community he hesitated, "Ms. Callahan then stated, 'They want to see that you can play nicely in the community. Just say yes,' after which Mr. B stated 'Yes.'" The Dr. asked William whether there was any risk he'd refuse to return to the hospital from a community trip; "Ms. Callahan told him 'Just say no,' after which Mr. B stated 'No.'" (Tab 23 - Progress Note by Daniel R. Filene, MD, pages 3-4)

Dr. Filene asked William about speaking with outpatient providers, Ms. Callahan responded that there would be no benefit in obtaining their opinions and William declined consent. When Dr. Filene asked if he could speak with William's mother, Ms. Callahan responded that his parents are a negative influence in his life and William decline consent. William said he would not undertake psychological testing with Dr. Gregor. When the Dr. inquired about his misgivings, "Ms. Callahan responded 'He said no, he doesn't have to answer anything else.'" "William is innately guarded about his mental state, and is further urged in this direction by his advocate who urges him to avoid revealing personal information. The opinions of those who know him best in the community are not available to me, again with the advocate's concurrence." Dr. Filene said he believed patient "most likely does have a psychotic illness" and would benefit from medication but will not take it. (Tab 23 - Progress Note by Daniel R. Filene, MD, pages 3-4)

Objective risk assessment elements: "Mr. B has psychotic thought patterns, which are not noticeably improved since admission and not currently treated with medication; Mr. B makes efforts to minimize these patterns and avoid their assessment/treatment; two hospitalizations in a year have been precipitated by reported violence or threatening behavior; a variety of incidents on the unit while not individually dramatic, suggest that Mr. B has underlying tendencies towards aggression and violation of societal norms." "Overall, as a best estimate, I currently feel Mr. Bruce represents an intermediate level of safety concern." (Tab 23 - Progress Note by Daniel R. Filene, MD, pages 4-5)

4/11/06 – Dr. Filene meets with William and says that he "continues to make a variety of grandiose, disorganized and likely delusional statements." For example, he states he is from a close-knit family, but he has over 200 relatives he's close to and then later he states he wants no contact with anyone in his family except possibly one uncle. (Tab 24 - Progress Note by Daniel R. Filene, MD, page 1)

William states his advocates are stating "he is not ill, not a danger and should be released." Dr. Filene notes that William feels these opinions have the same or more weight than that of mental health professionals. William continues to refuse medication. Dr. Filene informed William that the plan of his previous psychiatrist was, if his mental status remained the same, to reinitiate Emergency Involuntary proceedings at the end of his commitment, but that Filene would not do this assuming William's behavior did not worsen. (Tab 24 - Progress Note by Daniel R. Filene, MD, page 2)

Filene observed that William had no insight that he might have a mental illness. During the interview William appeared distracted by internal stimuli. Filene noted that Dr. Fliesser felt the patient was a serious risk, but this opinion was not held by most other staff. "Overall, as a best estimate, I currently feel Mr. Bruce presents an intermediate level of safety concern, and, given another week without incident, slightly lower than my initial assessment." (Tab 24 - Progress Note by Daniel R. Filene, MD, pages 2-3)

4/20/06 – "No recent threats/declined medication." "Since last review; in your clinical opinion does this patient pose any danger to self/or others? No." He will be discharged on 4/20 to a motel in Bingham, coverage will be with Andy Davis and will have a referral to Capitol Community Clinic for psych coverage. (Tab 25 - Service Plan Review signed by Treatment Team Members which include the client William Bruce, continuity of care manager whose name appears to be Kathryn (last name illegible), peer specialist whose name appears to be Heidi Smith, RN whose name is illegible, psychiatrist whose name is Daniel Filene, recreation therapist whose name appears to be Dan (last name illegible), Community support worker whose name is illegible, Treatment team coordinator whose name appears to be Larry Hayward, family member whose name is illegible and the patient advocate Patricia Callahan added a place for her name and signed her name)

4/20/06 – Meets criteria for acute hospitalization. "In ongoing review of Mr. Bruce's case with other staff, there were no particular concerns about his immediate safety." William and Patient Advocates continue to push for his release in advance of the expiration of his court commitment. Client, ICM, social worker, and Advocate continued to reiterate that patient had a secure discharge plan including housing with his friend Jesse. Dr. Filene said that "Although I continued to feel that Mr. B would benefit from additional treatment, specifically antipsychotic medication, it had become very clear to me that he would not accept this recommendation." "Mr. B appeared very unlikely to meet criteria for re-initiation of Emergency Involuntary status at the end of his court commitment on 4/30. Also it seemed extremely unlikely that any material change in his mental status or social situation would occur in the remaining time on his court commitment." Dr. Filene discusses plan of discharging patient on 4/24 but this date did not work for ICM Andy Davis who requested it be moved to 4/20 and Filene agreed to the advancement. (Tab 26 - Progress Note by Daniel R. Filene, MD)

After discussing this plan with William, Filene was informed Jesse was out of state until early May but Andy Davis arranged for William to stay at a hotel. Filene noted that "he weighed the potential increased risk of social isolation while using a hotel, against the importance of promoting the patient's trust in the mental health system by not reversing my agreement to discharge." At the team meeting Dr. Filene discussed the plan with ICM Davis who was comfortable with it and indicated he was nearby and could check on William frequently. Dr. Filene also discussed the situation with Dr. Nelson who felt it was reasonable under the circumstances to continue with discharge. Plan is for social work to schedule follow up with psychiatrist at Capitol Community Clinic. (Tab 26 - Progress Note by Daniel R. Filene, MD)

Amy Bruce killed on 6/20/06

7/31/06 – Transferred from the Somerset County Jail today for a Stage 3 evaluation. William is charged with his mother's murder. A significant portion of this Psychiatric admission assessment "is gleaned from his January 2006 Acadia hospital record and the subsequent transfer to RPC in February 2006." (Tab 27 - Psychiatric Admission Assessment by psychiatrist Carolyn Criss, page 1)

The admission assessment discusses William's past psychiatric history (left a suicide note as a late adolescent; last summer shot 30 rounds from an AK47 into the trees and then pointed it at his two friends and asked them if they knew anything about boys being sexually molested; admitted to Acadia hospital last January after an altercation with his father; had his mother in a judo type headlock to demonstrate he could break her neck, etc.) and discusses his past problems/diagnoses. (Tab 27 - Psychiatric Admission Assessment by psychiatrist Carolyn Criss, page 1)

William has delusions about his role as a CIA operative and is focused on the world problems. He mentioned it was not a coincidence his mother's death was the day before the current Israel war with Lebanon (actually those dates are 3 wks apart). Lacks capacity for insight and judgment is impaired. Appears to be able to understand risks and benefits of treatment. Criteria for discharge is no evidence of danger to self or others and demonstrated ability to care for self sufficient to meet daily basic needs, estimated time 30-60 days. "Medical necessity for Hospital Admission: Meets on basis of significant risk to seriously harm others." (Tab 27 - Psychiatric Admission Assessment by psychiatrist Carolyn Criss, pages 2-3)

8/07/06 – Upon admission the individual is not a danger to self but is a danger to others, meets medical necessity criteria for inpatient hospitalization. (Tab 28 - Individual Treatment and Discharge Plan signed by William Bruce, Carolyn Criss, continuity of care manager whose name appears to be Kate Leonard, nurses whose names appear to be Kim (last name illegible) and Patrick (last name illegible), community support worker whose name is illegible, peer support specialist whose name appears to be Eric (last name illegible), and a patient advocate whose name is illegible)

8/07/06 – William spoke about "delusions about being an undercover operative and expressing his desire to 'defect' to Russia. He believes his desire to defect will take precedence over any legal issues he may be facing at present." Staff observed him scanning the fence, there are real concerns about elopement risk. Psychological testing is needed to examine his symptoms objectively. He is refusing scheduled medications and maintains good control on the ward so he does not meet criteria for a psychiatric emergency. (Tab 29 - Progress note by Dr. Criss)

8/17/06 – "He denies psychotic symptoms but is easily distracted." He reports joining the army but could not give the rank he achieved and he said his father was in the military and his father is like "Joseph Stalin," which Dr. Criss found interesting given his motivation to defect to Russia and his report that his relationship with his father is not repairable. Psychological testing is needed and he continues to be considered an elopement risk and is restricted to the ward. He had his first session with State Forensics Service this week and another scheduled for next week. (Tab 30 - Progress note by Dr. Criss)

8/22/06 – William is discharged back to Somerset County Jail. He states that his mother was "assassinated" due to her connection with Hamas which started the current Israeli/Lebanese conflict. He was seen by the state forensic service and the psychiatric center was advised he was to be released to the Somerset County Jail. "He declined medications and treatment for the duration of his admission and never met criteria for a psychiatric emergency." (Tab 31 - Inpatient Discharge Summary by Dr. Criss)

10/4/06 – Court determined defendant is currently incompetent to stand trial and committed William to be placed in a mental institution. (Tab 32 - Order and Finding of Incompetence)

10/11/06 – 25 year old William was transferred to Riverview from Waldo County Jail after he was found to be incompetent to stand trial. "He is charged with the murder of his mother last June and was at Riverview this past August for a Stage III evaluation to determine his competency to stand trial. At that time he did not want treatment and did not believe he had a psychiatric illness. His focus was primarily invested in delusions that he is involved in espionage as an agent for Russia and voicing his plan to defect. He returns today complaining of feeling depressed for the past week and is willing to discuss medications. He is resolved to being here for a year." Medical Necessity for Hospital Admission: "Meets on basis of psychotic delusions which make him a significant risk to seriously harm others." (Tab 33 - Psychiatric Admission Assessment by Dr. Criss)

10/13/06 – "He has delusions of working with the KGB and is planning to ask for asylum from the Russian Embassy." (Tab 34 - Progress note by Dr. Criss)

STATE OF MAINE

PISCATAQUIS COUNTY PROBATE COURT   DOVER-FOXCROFT

In Re: William H. Bruce
DK # 2006-136

This matter came on for hearing on February 6, 2007. The proposed guardian, the father of the ward, appeared but did not produce the requisite medical report prior to hearing.

Findings: William H. Bruce is currently in Riverview Psychiatric Hospital having been committed to the custody of the Commissioner of Health and Human Resources by order of the Somerset Superior Court Docket # CR-06-298. He has been charged with the murder of his mother. The Superior Court entered an order and finding of incompetence dated 10-4-06 of which this court takes judicial notice.

Robert Bruce has made extensive efforts to secure medical reports regarding his son for the purposes of supporting his guardianship petition but has been unable to secure a current medical report. Those parties attending his son have for various reasons declined to either provide unfettered access for the purpose of an examination or to provide copies of prior examinations purportedly because of asserted privacy issues.

Mr. Bruce has previously filed a notice of intent to bring suit against various treating facilities because of events leading up to the death of the ward's mother and his wife. Mr. Bruce believes the resistance of the medical community to support this petition is as a result of this notice.

Mr. Bruce has submitted a report dated January 12, 2006 that provides an adequate basis for the appointment of a guardian but for its age.

The court also notes that this visitor supports the appointment of a guardian and that no objection or request for counsel has been forwarded to the court.

The court further notes that although the ward is in the custody of the Commissioner he has no guardianship protection nor are his assets being husbanded by any party with legal authority.

ORDER:

The proposed guardian finds himself in an unenviable position. He is unable to produce a report because he has no legal authority to obtain one and he cannot secure a guardianship appointment because he has no medical report to support it.

Given the extraordinary circumstances of this matter and the finding of the Superior Court this court believes that a guardianship for a period of 90 days is appropriate. This will allow Mr. Bruce both the time and authority to obtain such reports so as to allow this court to consider the entry of a permanent guardianship.

Dated: 2-8-07

James R. Austin
Judge of Probate Piscataquis County

A TRUE COPY
ATTEST: Judith A. Raymond
REGISTER OF PROBATE

THE WALL STREET JOURNAL.
WSJ.com

LEADER (U.S.) August 16, 2008

A Death in the Family

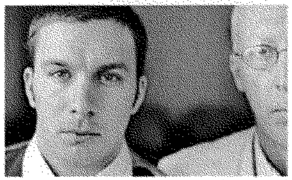
Aided by advocates for the mentally ill, William Bruce left the hospital -- only to kill his mother

By ELIZABETH BERNSTEIN and NATHAN KOPPEL

On June 20, 2006, William Bruce approached his mother as she worked at her desk at home and struck killing blows to her head with a hatchet.

Two months earlier, William, a 24-year-old schizophrenic, had been released from Riverview Psychiatric Center in Augusta, Maine, against the recommendations of his doctors. "Very dangerous indeed for release to the community," wrote one in William's record.

SEE FULL-SIZE IMAGE



Shoshanah White for The Wall Street Journal

William Bruce, left, with his father, Joe Bruce, who feared his son's release from a psychiatric facility.

But the doctor's notes also show that William's release was backed by government-funded patient advocates. According to medical records, the advocates -- none of them physicians -- appear to have fought for his right to refuse treatment, to have coached him on how to answer doctors' questions and to have resisted the medical staff's efforts to contact his parents. As one doctor wrote, William told him his advocates believed he is "not a danger, and should be released."

William's father, Joe Bruce, obtained his son's medical records from Riverview eight months after the killing. "I read through the records and I just remember crying all the way through," Joe Bruce says. "My God, these people knew exactly what they were sending home to us."

Helen Bailey, one of William's advocates, declined to discuss the details of his case but says the handling of it was consistent with her professional duties. "My job is to get the patient's voice into the mix where decisions are made," says Ms. Bailey, an attorney with Maine's Disability Rights Center in Augusta. "No matter how psychotic, that voice is still worthy of being heard. I have not had the person who is so out of it that they can't communicate what they want." She added that the records reflect the doctors' perception of what happened.

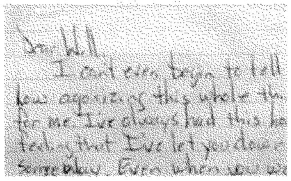
The story of William Bruce -- based on medical records made available to The Wall Street Journal -- as well as interviews with relatives, doctors, advocates and hospital administrators brings into sharp focus the impact of a little-known government-funded advocacy program for psychiatric patients.

Attempt to Curb Abuses

More

A Father's Call for Help: Excerpts from 911 call.
AmyBruce.org

SEE THE MOTHER'S LETTER



Congress created the national Protection and Advocacy for Individuals with Mental Illness program, or PAIMI, in 1986 to curb abuse and neglect of the mentally ill, primarily in institutions. In the 1960s and 1970s, many abuses were uncovered at hospitals, where patients were physically restrained, neglected or overmedicated.

The PAIMI program, operated by the Substance Abuse and Mental Health Services Administration with a 2008 budget of $34.8 million a year, funds protection-and-advocacy agencies in each state. Typically nonprofits, these groups sometimes receive supplemental funding from states. According to a 2007 SAMHSA report, the agencies served 19,000 people in 2006.

Some doctors, hospital administrators and mental-health veterans argue that advocates are endangering the mentally ill and the public by too often fighting for patients' right to refuse treatment. Many advocates "have a strong bias," says Robert Liberman, a director of a psychiatric rehabilitation program at the University of California, Los Angeles.

"I don't know if they are doing people a service when they assert the right of mentally-ill individuals to remain psychotic," says Ron Honberg, director of policy and legal affairs for the National Alliance on Mental Illness, an education, support and advocacy group.

Proponents of patient advocates say they're essential to protecting the rights of the mentally ill. The National Disability Rights Network, which provides lobbying and other services for the patient-advocacy system, says advocates play a critical oversight role.

They cite the 2006 sentencing of the owners of a Kansas treatment facility on charges that they subjected patients to forced labor and involuntary servitude, and a class-action lawsuit alleging that female patients of the Lincoln Regional Center in Nebraska were raped and assaulted by a male staff member. The latter case was settled in 2007 with the hospital, which denied liability, agreeing to more thoroughly investigate assault complaints.

The mentally ill are "very vulnerable," says Curt Decker, executive director of the National Disability Rights Network. "There needs to be an external, independent, legally based advocacy system to make sure they are being treated fairly, equitably and safely."

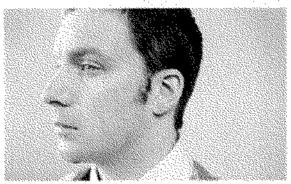
John Morrow, senior public health advisor at SAMHSA, declined to discuss the Bruce case. But he says advocates serve a very important function, and that the organization has resolved thousands of cases of abuse and neglect.

In recent years, there has been a wave of legislative efforts, many inspired by violent crimes, to make it easier to mandate treatment for the mentally ill. Advocates have blunted those efforts in California, New Mexico and Michigan.

In Michigan, advocates successfully pushed for limits to a 2005 law -- proposed after a schizophrenic killed a young man -- mandating outpatient treatment. "They have a left-wing, individual-rights-at-all-costs agenda," says Virg Bernero, mayor of Lansing, Mich., who helped pass the law when he was a state legislator.

"Our legal mandate is to protect the rights of individuals," says Elmer Cerano, executive director of Michigan's PAIMI chapter. But, he says, "rights are limited when it comes to safety."

Despite advocates' objections, Joe Bruce -- with the help of his pro-bono attorney, Robert Owen of Fulbright & Jaworski LLP in New York -- successfully lobbied the Maine legislature to pass three bills. One gives mental-health professionals greater leeway to disclose patient information to those who may be affected by that person's conduct. Another makes it easier to medicate involuntarily committed patients.



Shoshannah White for The Wall Street Journal

William Bruce, who killed his mother in 2006 after he was released from Riverview Psychiatric Center in Augusta, Maine. He was found not criminally responsible by reason of insanity for the crime and was recommitted indefinitely. He takes classes online through Colorado Technical University.

William Bruce grew up in Caratunk, Maine, a picturesque town of about 110 residents nestled in the state's northern hills. His father, a rugged, talkative man, worked as a senior technician for the Maine Department of Transportation. His mother, Amy, served as the town's treasurer. The oldest of three boys, William grew up in a 100-year-old farmhouse that sits on the banks of the winding, rock-strewn Pleasant Pond Stream.

Even when Willy -- as he was known as a boy -- was young, "there was just something different about him," his father says. Although cute and energetic, William was hyperactive and deeply self-centered, his father says. And he could turn suddenly violent: When he was four, he pushed his younger brother down the stairs. At five, he broke the same brother's leg, his father says.

As an adolescent, William was handsome, popular with girls and deeply troubled, attempting suicide at 14. He would sometimes see therapists, but would quit and stop taking any prescribed medication, Joe says.

William's behavior particularly pained his mother. Tanned and athletic, Amy loved kids, often hugging her own and opening her home to neighborhood children. But Joe says she was seldom able to emotionally connect with her eldest son, and repeatedly blamed herself for his problems.

After dropping out of high school, getting his equivalency degree and serving in the Army, William bounced among low-level jobs and had a few minor brushes with the law. On Christmas Eve, 2003, Joe says William had his first psychotic episode in a Target store, telling his father that the security cameras were monitoring him.

But he refused to seek treatment, and his family couldn't insist. Maine, like many states, requires that the mentally ill pose a substantial risk of harm to themselves or others, based on recent evidence, to be involuntarily committed.

In March 2005, after William threatened two men with a loaded AK-47 assault rifle -- his father is a licensed gun dealer -- William went to a psychiatric facility in Bangor. He was eventually released but stopped taking his medicine.

William deteriorated. Sometimes he walked into neighbors' homes unannounced. Once he put his mother in a headlock. In January 2006, William punched his father in the face, screaming, "You have disobeyed direct orders from a superior officer in the CIA." He was sent on Feb. 6, to Riverview, an extended-care psychiatric facility.

'An Awful, Awful Feeling'

"We were certain he would be released," Joe Bruce says. Waiting for that day "was an awful, awful feeling."

A few weeks after William Bruce's admission, psychiatrist Jeffrey Fliesser wrote that William was hostile, paranoid and "dangerous to others without additional observation and active attempts to treat him," an opinion he reiterated over the next five weeks. The doctor also wrote that he urged William, now diagnosed with paranoid schizophrenia, to take medication, but William refused. Dr. Fliesser declined to comment about the case for this story.

William began working with advocates employed by the Maine Disability Rights Center, which receives funding from the federal PAIMI program as well as state and private sources.

According to a nurse's treatment record dated March 23, Ms. Bailey, the advocate, told Riverview administrators she saw no documentation showing that William should remain hospitalized. Trish Callahan, another advocate, suggested that William "may actually be getting worse by remaining here," the nurse's record says.

"I repeatedly explained to the patient, his advocates and other team members, his paranoid psychosis will not likely improve without medication therapy," Dr. Fliesser wrote in his notes. Ms. Bailey says she gives legal opinions, not clinical ones, and notes that her job is to represent the client's wishes.

By the beginning of April, William Bruce's case was "in a high state of contention," wrote Daniel Filene, a psychiatrist who had taken over the case. On April 6, Trish Callahan, another advocate, attended a meeting with William's treatment team. She stressed that William should be discharged and that his summer job prospects were being harmed by his continued hospitalization, Dr. Filene's notes say.

According to these notes, Dr. Filene suggested to William that he take trips outside the hospital. When William voiced reluctance to venture out, Ms. Callahan told William, "They want to see that you can play nicely in the community. Just say 'Yes.' " He did. Dr. Filene asked William if there was a risk he would refuse to return to the hospital from a community trip. "Ms. Callahan told him, 'Just say no,' and Mr. B. replied, 'No,' " the doctor wrote in his notes.

Dr. Filene wrote that he asked William for permission to speak to his mother and his previous mental-health providers. Ms. Callahan said there would be no benefit and that William's parents were "a negative force in his life." William refused to give consent, Dr. Filene's notes say. On April 11, Dr. Filene wrote that William said his advocates were telling him that he is "not a danger and should be released."

Ms. Callahan didn't respond to requests seeking comment. Dr. Filene declined to comment about the case for this story.

"I think the advocates overstepped their bounds," says Riverview Superintendent David Proffitt. William "was relying on the people whose purpose it was to ensure his civil rights were being exercised, and unfortunately that interfered with his other right, which was to get medical care."

Ms. Bailey, Ms. Callahan's superior, doesn't believe the advocates prevented William from getting medical care. "There is nothing in the William Bruce case that is contrary to the way we do business," she says, adding that it is the hospital's responsibility to try to have a patient committed or forcibly medicated.

William Gets Released

More generally, Ms. Bailey says it isn't a given that families of the mentally ill should be involved in decisions involving their care. "There are some God damn nasty families out there," she says. SAMHSA declined to comment on the case, as did the Maine Department of Health & Human Services.

In the end, Dr. Filene wrote that while he recommended William stay at Riverview, William appeared very unlikely to meet Maine's legal criteria for further involuntary hospitalization beyond his court-ordered commitment term, which expired at the end of April. On April 20, 2006, William was discharged.

William was soon back home. He hid steak and butcher knives in his bedroom and spent hours pacing in the driveway, giggling and babbling unintelligibly to himself. Joe began calling to check on his wife several times a day. "It was the worst we'd ever seen him," he says.

On June 20, two months after his son's release, Joe Bruce returned home from his office to find his wife's battered, bloodied body. William was gone.

"My son has killed my wife," Joe told the 911 dispatcher, later adding that he was arming himself in self-defense.

According to the medical examiner's report, Amy died of multiple blunt-force trauma and chop injuries to her head. She was 47 years old.

Police arrested William Bruce at his grandparents' house and later charged him with killing his mother. He told a psychologist that the Pope told him to kill his mother because she was involved with al Qaeda and Saddam Hussein. Joe Bruce became William's legal guardian and gained access to his medical records.

When police returned Amy Bruce's purse to Joe, he found an unsent letter she had written to her eldest son.

"I've always had this horrible feeling that I've let you down in some way," she wrote. "The only wish I have is that someday we can look each other straight in the eyes and say I'm sorry and I love you more than life itself." She added: "I will not give up on you ever."

In March 2007, William was found not criminally responsible by reason of insanity and was committed to Riverview again, this time indefinitely. At the end of 2007, faced with the possibility of being restrained and medicated against his will, William agreed to take Abilify, an antipsychotic drug. Within weeks, his mental status improved.

'I Blame Myself'

William Bruce, now 26, is strikingly handsome, his dark hair slicked back. Sitting in a Riverview conference room on July 23, he spoke courteously but deliberately. It was the first time he has been interviewed about his case.

"I blame the illness, and I blame myself," William said of his mother's death. "The guilt is...," he paused, struggling to find a word "...tough."

William said the first time he came to Riverview, he refused to believe he was mentally ill and approached the advocates because he wanted out.

"They helped me immensely with getting out of the hospital, so I was very happy," he said. He later added, "The advocates didn't protect me from myself, unfortunately."

These days, William is taking criminal-justice classes online through Colorado Technical University. He points proudly to his 3.94 grade-point average and says he hopes to attend law school to learn more about mental-health laws. William and his father talk on the phone almost every day. "He stood by me the whole time despite the horrible tragedy...despite what I did," William said. "I am the man I am today because of my dad."

While William believes patients deserve some protection, he said he understands his father's fight to strengthen commitment and treatment laws. That fight took another turn last month, when Ms. Bailey and another attorney filed a lawsuit that could undermine portions of a law Joe supported. The suit, filed in U.S. District Court in Maine, is directed at the law which makes it easier for hospitals to compel patients to take medication.

"There are times when people should be committed," William said. "Institutions can really help. Medicine can help."

"None of this would have happened if I had been medicated."

Write to Elizabeth Bernstein at elizabeth.bernstein@wsj.com and Nathan Koppel at nathan.koppel@wsj.com

NATIONAL
DISABILITY RIGHTS
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Protection & Advocacy for Individuals with Disabilities

SUMMARY IN RESPONSE TO WSJ ARTICLE

DRC staff attended a treatment and discharge planning meeting for William Bruce on March 23, 2006. As of that date William Bruce already had been a patient at RPC for more than 6 weeks. Throughout that period he had declined medication and the hospital had taken no action to initiate forced medication procedures.

The treating doctor entered a note on March 23 stating that William Bruce "remains competent to give or refuse informed consent."

A pre-condition for the non-emergency involuntary administration of medication under the Maine regulations as they applied at that time was that an individual must be found to lack capacity to give informed consent. Lacking capacity to give informed consent remains a requirement in Maine law even now.

As of March 23, William Bruce was within a few days time when a petition for recommitment would need to be filed. Under Maine Law at the time, the hospital was required to file an application for recommitment 30 days prior to expiration of the then current commitment.

A DRC attorney reviewed the documentation and expressed concern at a team meeting that the documentary evidence in the record would not support the legal standard for Mr. Bruce's recommitment. DRC staff also asked if the hospital would be amenable to obtaining an independent evaluation. DRC believes this is an appropriate request when a patient either is not engaging in or is not responding to the treatment the hospital is offering.

When a hospital has taken no action to recommit, a patient may leave at the end of a commitment with no plans for community services. Because of this, DRC consistently advocates with hospital social workers to assure adequate discharge planning. This includes issues such as housing, employment, income, psychological and psychiatric services, case management and other supports. DRC also provides information regarding services available in the community directly to the patient.

In early April, a new treating physician was assigned to Mr. Bruce. The new treating psychiatrist assessed Mr. Bruce as "not likely to meet criteria for re-initiation of emergency involuntary status" and arranged for discharge to occur.

The decision to apply for recommitment is a hospital decision. The hospital took no action to recommit Mr. Bruce. The hospital's Medical Director was actively involved with Mr. Bruce's care and could have directed that an application be initiated if he felt it was needed.

When Mr. Bruce was discharged on April 20, 2006, the doctor developed a plan which included an intake appointment with a therapist the following week and direction to the social work department to schedule a follow-up appointment with a psychiatrist at the clinic located in the hospital. Mr. Bruce had been encouraged to attend even though he was not taking medication.

Mr. Bruce also had an Intensive Case Manager (ICM) whom he had met with while still a patient at RPC, and who had been in contact with the hospital social worker and psychiatrist. An ICM is a state employee charged with responsibility for, among several other responsibilities, assessing client needs, arranging for and monitoring delivery of services and for ensuring the delivery of necessary crisis intervention services.

OTHER ACTIVITY:

Helen Bailey participated, along with William Bruce's father, on a "think tank" organized by NAMI ME to come up with strategies for addressing barriers to access to mental health services. Along with NAMI and provider representatives, Helen Bailey actively supported recommending increased development of low-barrier services, such as peer run social clubs, targeted to engaging individuals otherwise not engaged with mental health services. Helen Bailey also supported expansion of the "Portland Identification and Early Referral Program (PIER)" at Maine Medical Center to other areas of the state. When the state experienced serious budget shortfalls, this group disbanded.

DRC had opposed enactment of the Progressive Treatment Program (a type of outpatient treatment program). Helen Bailey sat on a committee charged with making recommendations to the legislature on the issue of outpatient commitment. Members of the group recommended amending the inpatient commitment law by shortening the time frames between an emergency admission and a court commitment so that should involuntary medication procedures need to be initiated, they could be resorted to sooner. DRC supported this amendment.

DRC participated on the committee to consider jail diversion and development of a mental health court. A mental health court was developed for the Kennebec County area following the recommendations of this committee.

DRC did oppose LD 1033, a bill designed to amend provisions governing involuntary administration of medications. Helen Bailey participated with other interested individuals to consider amendments to the bill, and proposed and drafted several options that combined early access to procedures along with due process protections.

DRC sat on a committee to examine the needs of individuals in nursing homes and worked with other interested individuals to amend the preadmission screening and resident review process to better assure that the mental health needs of such individuals were being properly assessed.

DRC worked with departmental staff and legislators to develop final language of a bill that created a forensic review panel to review deaths and other incidents involving individuals with mental illness. It addresses instances where individuals with mental illness are victims or the individuals charged with the crimes.

DRC supported amendments to the commitment statute that revised that portion of the law that mandated dismissal of a commitment application if the two independent examiners found that an individual did not meet commitment standards, and permitted a hospital to proceed if it disagreed with this assessment. In connection with this bill, DRC recommended that the time within which a hospital need apply for recommitment be reduced from 30 days to 21 days in light of the fact that commitments can be as short as 30 to 45 days.

Helen Bailey has been counsel for the plaintiffs in the case now captioned Bates v. Department of Health and Humans Services, since the case was first initiated in 1989. In accordance with the terms of the settlement agreement in this case, the state has developed significant resources to address the housing, vocational, treatment and other needs of individuals with mental illness.

NATIONAL
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Protection & Advocacy for Individuals with Disabilities

About Bruce Case – If you receive media queries on this topic, we want you have talking points about the case. If you don't feel comfortable, please forward any media calls to Curt Decker at NDRN or Kim Moody at the Disability Rights Center of Maine.

- Mrs. Bruce's death was a terrible tragedy.
- The WSJ article suggested that the Disability Rights Center (DRC) of Maine caused Mr. Bruce's release. However, because the hospital had taken no action to legally recommit him, he was due to be discharged anyway.
- DRC reviewed the medical record and alerted the facility that it appeared they did not have adequate legal documentation to hold Mr. Bruce beyond his already scheduled discharge date.
- When a psychiatric facility takes no such action to recommit, or when there does not seem to be sufficient evidence to support recommitment, as the DRC pointed out to the facility in this case, DRC advocates with hospital social work staff to develop and implement a quality discharge plan including housing, employment, case management, counseling and other support services.
- Since its inception in 1986, the DRC's PAIMI program has worked hand-in-hand with the State Department of Health and Human Services, the Maine Legislature, provider & consumer organizations and the Maine chapter of the National Alliance on Mental Illness (NAMI) to enhance and improve community supports and services for people with mental illnesses.
- Over the past five years, the program has provided direct representation to 1,791 people, among them were 360 cases involving abuse and 127 relating to neglect. The program has provided training and group advocacy to countless others.

About PAIMI / Advocacy Work

- Founded in 1986, the Protection & Advocacy for Individuals with Mental Illness (PAIMI) program has been a very successful program both in Maine and throughout the United States. In 2007 alone the program closed 16,000 cases, of which 4,200 were related to abuse, 3,300 to neglect, and 8,500 to a violation of individual rights.

- PAIMI uses a broad range of strategies to resolve issues including short-term technical assistance, investigations of incidents and administrative remedies. Less than 3 percent of cases result in legal action being taken.

- The Program Assessment Rating Tool (PART) program provides real data on the impact of the program. The HHS Office of Inspector General report states that P&A advocacy efforts have had a major impact on how states and facilities protect the rights of persons with disabilities.

12/16/06
Gardiner, ME

Dear Mr. Bruce,

I am writing to you as a stranger, I know, but I have followed the tragedy of your son's illness and subsequent death of your wife for many weeks, thru the media. Please accept my deepest sympathy for what you are enduring.

It's not as if I am totally unaware of the mechanics of Riverview. After working there as a nurse for 22 yrs (and loving the work I did with the patients) I was exposed to a new group of administrators, who were chosen to expedite closure of AMHI and to build a small hospital (and hopefully release the state from the Consent Decree).

Therefore, the Recovery Model was introduced, allowing pts to make their own treatment decisions—even when this included med refusal.

Those of us who had worked with brain diseased patients for years, knew that their were times when a patient's decision to opt out of medication therapy could be the result of psychotic thinking, and that decision had to be over ridden by clearer thinking caretakers. Generally, we had seen med compliant patients, whose symptoms would remit BECAUSE of the medication. We all believed the analogy of mental illness being like diabetes—treatable with positive results, IF MED COMPLIANCE OCCURRED. But, young people are often in denial and the meds are far less than perfect, and, sometimes, caused some nasty side effects, so doctors always tried to minimize the dosage against resumption of symptoms. But, between the administrators and advocates, a "Recovery" theory became the rule, encouraging patients to make their own treatment decisions.

Perhaps this is why there is not one permanent staff physician @ Riverview, and "rent-a-docs" provide the in-patient care.

Many of us have left Riverview –after years of hard, but fulfilling work—because it has all become more political than clinical. Anyone who loves the mentally ill, and understands their struggles and the pain, which they and their families endure, have not been able to work in a systems which NO longer focuses on the best interest of the patient.

So, Mr. Bruce, I hope you proceed with your litigation against the state, because your losses didn't happen for reasons other than your family's misfortune to become involved with the mental health system, when politics (now) override sound medical decisions.

With sorrow for your losses,
Maria Champine RNC

From: William H. Bruce II

Riverview Psychiatric Center

250 Arsenal St.

Augusta, Me 04330

To: Members of Health and Human Services Committee, Sen. Joseph C. Brannigan, Sen. Lisa T. Marraché, Sen. Peter Mills, Rep. Anne C. Perry, Rep. Patricia Jones, Rep. Mark Eves, Rep. Matthew J. Peterson, Rep. Linda F. Sanborn, Rep. Peter C. Stuckey, Rep. Sarah O. Lewin, Rep. James J. Campbell, Sr., Rep. Henry L. Joy, Rep. Meredith N. Strang Burgess, Rep. Donald G. Soctomah

April 27, 2009

Dear Committee,

I'm writing you in support of LD1360. My name is William Bruce and I'm a patient at Riverview. I have been committed here for almost three years. I was committed because on June 20th of 2006 I killed my mother. I have been living in sorrow since.

Life has been very difficult for me at times but with the hospitals help and medication I get by. I would like to talk about the importance of medication in my life. Before the crime happened I was hospitalized but I refused medication. If I had been on medication and in an outpatient treatment program I would not be writing you this letter today. I struggle with this on a daily basis. At the time everything seemed clear to me. I was a clandestine operative and I believed my mother was an Al Qaeda operative and I was being ordered to kill her. I did not realize how distorted my mind was and how much the delusions had taken over. My dad tells me everyone could see there was something wrong with me but I couldn't. This is when I should have been treated.

After I arrived back at the hospital I was still refusing medication, this is when my father stepped in and became my guardian. The hospital told me I would have to start taking medication or they would force me to. So in late 2006 I started a medicine regime. I don't really know how to describe the change; all I can tell you is that the medicine worked well for me. It actually took a medicine change before I found one that worked the best for me. I'm currently on abilify. Waking up and realizing what I did, had a major effect on me at first and still does today.

Today I have a better grip on things thanks to Dr. Fischer and hours of treatment. Treatment is another important part of the medicine, without it you are running blind. The education you receive at the hospital is designed to work with the medication and help you understand your own illness. I'm not going to tell you I have had it easy because it hasn't been. It has actually been very difficult. It took me a long time to accept that I even had a mental illness but the longer I was on the medication the clearer things became. I know I will most likely have to take medication for the rest of my life. I have resigned myself to that fact but others haven't others who need the medication. It took a lot to get to this point today but I'm here and I will continue to go forward.

At the current point in time I'm allowed to go into the community a couple times a week with supervision. I also work grounds maintenance five days out of the week for two hours. I just recently got an associate degree after two years of hard work. You could say I keep myself very busy.

I'm writing you in support of LD1360 because I see firsthand what the benefits of medication are and what would happen if someone who is diagnosed with a mental illness and prescribed medication goes off of them. It is not healthy for the person taking them or the people around them. LD1360 will help keep people on their medication.

Sincerely,

William H. Bruce II

FRED UPTON, MICHIGAN
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
RANKING MEMBER

ONE HUNDRED THIRTEENTH CONGRESS
Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
2125 Rayburn House Office Building
Washington, DC 20515–6115
Majority (202) 225-2927
Minority (202) 225-3641

June 6, 2013

The Honorable Pamela S. Hyde
Administrator
The Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road
Rockville, MD 20857

Dear Administrator Hyde:

Thank you for appearing before the Subcommittee on Oversight and Investigations on Wednesday, May 22, 2013, to testify at the hearing entitled "Examining SAMHSA's Role in Delivering Services to the Severely Mentally Ill."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions by the close of business on Thursday, June 20, 2013. Your responses should be e-mailed to the Legislative Clerk in Word format at brittany.havens@mail.house.gov and mailed to Brittany Havens, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Tim Murphy

Tim Murphy
Chairman
Subcommittee on Oversight and Investigations

cc: Diana DeGette, Ranking Member, Subcommittee on Oversight and Investigations

Attachment

Responses
Questions for the Record
House Committee on Energy and Commerce
Oversight Hearing
May 22, 2013

The Honorable Tim Murphy

1. **I appreciate your agreeing to stay for the testimony of Joe Bruce, who appeared on our second panel at the May 22 hearing. The role played by advocates from the Disability Rights Center, the designated agency for administering the Protection and Advocacy for Individuals with Mental Illness (PAIMI) program in Maine, in obtaining the premature release of Mr. Bruce's son, William, from Riverview Psychiatric Center, is very troubling to me.**

   a. **Aside from audits, what kind of regular oversight does SAMHSA perform over recipients of PAIMI formula grants?**

   Response: SAMHSA provides rigorous oversight of the grants it awards. Grantees must fulfill their role in regard to the stewardship of Federal funds, and as such, SAMHSA grants management and project officers work collaboratively to identify potential problems and areas where technical assistance might be necessary. This active monitoring is accomplished through review of reports and correspondence from the grantee, audit reports, site visits, and other information available to SAMHSA. As a condition of award, grantees must provide specific information to SAMHSA on the management, performance, and accountability of the SAMHSA grant they run. Reporting requirements include a Federal Financial Report on an annual basis and must be submitted to SAMHSA for each budget period as stated, either a quarterly, semi-annually, or an annual progress report. OMB Circular A-133 now requires that all grantees receiving over $500,000 in Federal funding submit a data collection form in addition to the audit report, due by the earlier of 30 days after receiving the report or nine months after the end of the fiscal year. Quarterly financial reports that provide an overview of cash status are required by the Department of Health and Human Services (HHS) Division of Payment Management. The Federal Financial Report is the mechanism for reporting disbursements. Failure to submit reports by the specified due dates can result in fund access restrictions. Programmatically, SAMHSA project officers monitor the conduct and progress of grants, and collaborate with grantees in planning, implementation, and evaluation activities. Project officers' interactions with grantees might include answering questions about specific policies, advising grantees on programmatic issues, providing technical assistance, and requesting clarification about required documents as necessary.

   b. **What mechanisms has SAMHSA put in place, if any, to enable individuals, like Mr. Bruce, with concerns about the practices of SAMHSA's state-by-state designated PAIMI organizations, to communicate these concerns to SAMHSA?**

Response: Individuals may exercise their right to file a grievance with the Protection and Advocacy (P&A) system under the Protection and Advocacy for Individuals with Mental Illness Act (PAIMI Act) (42 U.S.C. § 10805(a)(9)) and regulations (42 CFR 51.25). Complaints that allege fiscal mismanagement, discrimination, etc. may be reported directly to SAMHSA, for review and further action. Individuals may also submit complaints to the HHS Office of the Inspector General (OIG). Likewise, individuals may also submit concerns to their governors' offices, since, by statute, the governor of each state designates, with HHS approval, the entity to which SAMHSA provides the PAIMI funds. If the issue of concern has to do with actions of the P&A entity conducted with other than SAMHSA funding, state action may be the most appropriate venue.

Anyone is welcome to express a concern to SAMHSA, and the appropriate staff person will address the concern or make a referral to the appropriate body that can do so.

c. **Does SAMHSA have criteria, or an established standard, against which to judge the appropriateness of a PAIMI grant recipient's advocacy efforts?**

Response: PAIMI project officers and grants management staff provide routine fiscal, programmatic, and monitoring oversight of all aspects of PAIMI formula grants within states. In this capacity, the project officer and grants management specialist monitor work to ensure that Federal PAIMI funds are being used consistent with the statutory authority and in compliance with PAIMI application requirements and annual program priorities established by the respective PAIMI Advisory Councils.

i. **What would SAMHSA do, if anything, if it had reason to question whether a PAIMI grant recipient, such as the Disability Rights Center, is in fact acting in the long-term best interests of a patient such as William Bruce?**

Response: SAMHSA receives allegations and complaints relating to health and safety concerns both from the OIG Hotline and directly from individuals. Upon receipt, SAMHSA's point-of-contact convenes a meeting with appropriate program officials. The most common and first response to health and safety allegations is normally to issue a letter to the grantee requiring it to specifically respond to each allegation. A follow-up conference call would be held with grantee officials to go over any related concerns. If these steps do not dispel the health and safety allegations, or if the allegations were considered severe in the first place, program officials would conduct a site visit, develop a corrective action plan (CAP) addressing the confirmed issues, and issue the CAP to the grantee with a deadline for completion. Classifying a grantee as high-risk, which involves imposing restrictions on the grantee's ability to drawdown grant funds, would not alone remedy health and safety issues, but may be utilized to encourage the grantee to implement the CAP.

d. **Do you believe that all of the activities performed by the Disability Rights Center, as set out in Mr. Bruce's testimony, were consistent with his son's best interests?**

Response: SAMHSA is unable to confirm that all of the activities performed by the Disability Rights Center were done as set out in Mr. Bruce's testimony. SAMHSA does not have statutory authority to intervene in individual cases to determine the best interests of each individual served by the PAIMI system. Rather, SAMHSA's role is to assure the entity designated to receive these Federal funds is complying with the requirements of the Federal funding. Concerns about these issues would be explored by SAMHSA staff. If concerns are brought to SAMHSA's attention regarding the actions of an individual attorney or advocate in an individual situation, SAMHSA would direct the individual concerned to the governor's office, to the state bar association responsible for oversight of attorneys licensed by that state, or in some cases to the state mental health authority if broader treatment or services issues are identified.

e. **Do you believe that the Disability Rights Center may have been better advised not to advocate for Mr. and Mrs. Bruce to be completely shut out of their son's treatment at Riverview?**

Response: SAMHSA's Guiding Principles of Recovery include numerous mentions of the importance that family members play in the recovery process and explicitly states that "[i]ndividuals, families, and communities have strengths and resources that serve as a foundation for recovery."

f. **Since the establishment of PAIMI in 1986, has there ever been an instance where a SAMHSA-funded PAIMI organization has engaged in advocacy for or against pending legislation either on the Federal or State level?**

Response: SAMHSA is not aware of any instance of a PAIMI organization using Federal funds to engage in advocacy for or against pending legislation at either the state or Federal level. Entities designated to receive these Federal funds may have other sources of funding in addition to PAIMI funding and may have additional responsibilities in addition to PAIMI responsibilities.

2. **In 1986, Congress established PAIMI to help families and individuals with psychiatric illnesses or developmental disabilities who were being abused or neglected. In its 2011 "Evaluation of the PAIMI Program, Phase III: Evaluation Report," SAMHSA states that Congress had an "expectation that PAIMIs [would] address both individual abuse and neglect cases and systemic deficiencies." This report suggests that SAMHSA can identify "more realistic performance indicators...when estimating the impact of systemic advocacy and policy work" by PAIMI grant recipients.**

a. **Please identify the specific statutory language authorizing recipients of PAIMI grants to engage in systemic advocacy or policy work.**

Response: 42 U.S.C. § 10805(a)(1) authorizes P&A systems to: (1) investigate incidents of abuse and neglect of individuals with mental illness if the incidents are reported to the system or if there is probable cause to believe that the incidents occurred; (2) pursue administrative, legal, and other appropriate remedies to ensure the protection of individuals with mental illness who are receiving care or treatment in the state; and (3) pursue administrative, legal, and other remedies on behalf of an individual with mental illness. The legislative history of the Act indicates that the Congress (S. Rep. No. 100-454, at 7 (1988)) intended that PAIMI authorize activities of protection and advocacy systems which address systemic deficiencies that could lead to abuse and neglect:

> During the reauthorization hearing on the Act, several witnesses spoke of systemic conditions that negatively impact the working environment encountered by direct care workers. These adverse conditions include inadequate staffing levels and inadequate staff training ... The Committee recognizes that in some facilities efforts of even the most dedicated care staff to provide quality treatment continue to be frustrated by such systemic conditions, which can foster abuse and neglect. The Committee believes that the protection and advocacy activities authorized in this legislation will have a positive impact upon the working environment.

Consistent with congressional intent, PAIMI's implementing regulations direct protection and advocacy systems to carry out systemic advocacy, *i.e.*, "those efforts to implement changes in policies and practices of systems that impact persons with mental illness" (42 CFR 51.31(f)).

b. **Describe how SAMHSA collects and evaluates data of individual cases versus systemic cases closed under PAIMI in order to measure performance.**

Response: The annual Program Performance Report (PPR) mandated by the PAIMI Act (42 U.S.C. § 10805(a)(7)) includes outcome statements that describe or relate to the initial complaints of abuse, neglect, rights violations, and group (systemic) activities used on behalf of the clients served. The PPR from each P&A provides data on the number and types of individual cases of alleged abuse, neglect, and rights violations. The PPR also includes an outcome measure for each closed case that indicates if the case was resolved in the client's favor and resulted in positive change for the client in her/his environment, community, or facility. These data allow for review of the positive percentage rates for each of these three areas as well as a combined measure for longitudinal change over time for the individual PAIMI programs. The data also allow for comparison among the other P&As in the system and can be used to track improvement and to target areas that may need some corrective action.

3. **After hearing Mr. Bruce's testimony, do you plan to follow-up with the Disability Rights Center in any way about their use of SAMHSA funding under the PAIMI program going forward?**

Response: The SAMHSA project officer is in continual contact with this and other PAIMI grantees regarding the appropriate use of Federal funding.

4. **Mr. Bruce mentioned in his testimony that when he approached the Maine legislature to press for an improved Assisted Outpatient Treatment law, he was shocked to encounter public opposition from the Disability Rights Center. What affirmative steps, if any, does SAMHSA take to ensure that its grant recipients, including recipients of formula grants under the PAIMI program, do not use any federal dollars to lobby for or against proposed legislation at the local, State, or Federal level?**

Response: SAMHSA's Request for Applications (RFA) includes the following language:

> Disclosure of Lobbying Activities – Federal law prohibits the use of appropriated funds for publicity or propaganda purposes or for the preparation, distribution, or use of the information designed to support or defeat legislation pending before the Congress or state legislatures. This includes "grass roots" lobbying, which consists of appeals to members of the public suggesting that they contact their elected representatives to indicate their support for or opposition to pending legislation or to urge those representatives to vote in a particular way. You must sign and submit this form, if applicable.

All applicants must complete the Disclosure of Lobbying Activities, if applicable. All grant applications must include a signed face page by the authorized representative which states that he/she agrees that the statements contained in the list of certifications are true, complete and accurate and agree to comply with any resulting terms if the Notice of Award.

All Notices of Award include a Standard Term and Condition that prohibits grant funds from being used for lobbying. Section 503 of the Labor, HHS, and Education Appropriations Act language is also included in all L/HHS-funded RFAs and standard terms & conditions.

In addition, SAMHSA has offered courses to staff that incorporate the prohibition on using Federal funds for lobbying. These courses include Appropriations Law for Business Operations in Government and The Legislative Process: Working with Congress.

Specific to the PAIMI program, the Fiscal Year (FY) 2013 RFA included the following PAIMI Grant Award Terms and Conditions:

1) That each PAIMI grantee submit a *Disclosure of Lobbying Activities* form [OMB approved 0348-0046, Standard Form LLL (rev. 7-97)].

2) Breach of Terms and Conditions: A State P&A system will be considered in breach of the terms and conditions of this grant award *for failure to satisfy any other requirements under the Act, CFR, or any other requisites*, e.g., compliance with SAMHSA audit, on-site monitoring and/or technical assistance recommendations within specified time frames.

   A breach of the terms and conditions will require remedial action, which may include the following SAMHSA actions: recommendation for suspension or termination of the PAIMI Program grant; conversion to a reimbursement method of payment; and/or agency retention of grant payments. [PAIMI RFA FY 2013].

3) Lobbying Prohibitions: No part of any appropriated funds contained in this Act may be used other than for normal and recognized executive-legislative relationships, for publicity or propaganda purposes, for the preparation, distribution, or use of any information kit, pamphlet, booklet, publication, radio, television, or video presentation designed to support or defeat legislation pending before the Congress, except in presentation to the Congress itself or any State legislature. *This includes "grass roots" lobbying, which consists of appeals to the public suggesting that they contact their elected officials to indicate their support for or opposition to pending legislation, or to urge those representatives to vote a particular way.* (Emphasis added)

   No part of any appropriation made under this Act may be used to pay the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any direct lobbying activity designed to influence legislation or appropriations pending *before the Congress or any State legislature.* (Emphasis added)

PAIMI grantees are also made aware that lobbying with Federal funds is prohibited by applicable regulations (42 CFR 51.6(b)), which state that "[Federal a]llotments may not be used to support lobbying activities to influence proposed or pending Federal legislation or appropriations. This restriction does not affect the right of any P&A system, organization, or individual to petition Congress or any other government body or official using other resources."

As a reminder, on June 12, 2013, Paolo del Vecchio, Director of SAMHSA's Center for Mental Health Services (CMHS), sent a letter to each PAIMI grantee reiterating this information.

5. **Are the majority of reviewers of SAMHSA competitive grants individuals who have specific advanced training and academic and professional credentials in the mental health fields rather than just experience, yes or no?**

Response: Yes, a majority of peer reviewers have advanced training and academic and professional credentials relevant to the behavioral health and other fields appropriate to the program under review. In the selection of peer reviewers, staff adheres to SAMHSA Extramural Policy Statement 11-02. This guidance outlines six key factors in the selection of an appropriate committee of reviewers, including "experts from various areas of specialization within relevant professional, technical and scientific fields."

6. **Your name is listed in the credits for a SAMHSA staff musical held December 1-3, 2010, and titled "A Place for Us." What role did you have in the planning and execution of this play?**

   Response: The Administrator had no role in the planning and execution of the musical, which was about HIV/AIDS and substance abuse and mental health issues. At the request of the staff, the Administrator along with three other SAMHSA staff recorded a short song, which was played during the musical. The recording was done without professional help and without cost to the agency and was done on a break from work lasting only a few minutes.

7. **Is SAMHSA planning a staff musical for 2013?**

   Response: No, SAMHSA is not planning a staff musical for 2013.

8. **On March 9, 2009, President Obama released a memorandum committing that "science and the scientific process must inform and guide decisions of my Administration on a wide range of issues, including improvement of public health." This memo instructed the Director of the Office of Science and Technology Policy to guarantee scientific integrity, noting that "the selection and retention of candidates for science and technology positions in the executive branch should be based on the candidate's knowledge, credentials, experience, and integrity."**

   a. **Are recipients of SAMHSA competitive grants, in each and every case prior to awarding of the grant, subjected to rigorous, blind peer review?**

      Response: Yes, all competitive grant applications are subject to an identical and rigorous peer review process.

   b. **What steps does SAMHSA take to ensure that grant reviewers for a particular competitive grant do not stand to financially benefit from approval of that grant? What conflict of interest policies does SAMHSA have in place for its grant reviewers?**

      Response: SAMHSA performs due diligence with regard to peer reviewer conflict of interest. In considering potential reviewers, SAMHSA will not allow individuals to review applications if their organization applied for that grant of if they have a general appearance of a conflict of interest, such as being a technical assistance provider to potential applicants. In addition, upon receiving assigned applications to evaluate, the first action a reviewer must take is to sign a form attesting that they do not have a conflict of interest with any of the applications under review.

   c. **Does SAMHSA require that those who evaluate grant applications for science quality and integrity hold advanced degrees in social work, psychology, and psychiatry?**

Response: SAMHSA grant reviewers are individuals who possess the specific knowledge and skill sets necessary to implement and therefore review for a specific program. When an RFA is published, the Review Administrator in the Division of Grant Review (DGR), a unit within SAMHSA's Office of Financial Resources, identifies three to five specific areas of expertise that are necessary. The Review Administrator then searches DGR's Peer Reviewer Database for individuals with these areas of expertise and seeks recommendations from program staff. The Review Administrator makes an initial selection of a large pool of reviewers and sends an e-mail to determine potential interest and availability to participate in the review of applications to the program. If an individual is interested, s/he must submit a Reviewer Contact Information form which updates their areas of expertise, resume or CV, and a paragraph outlining how their expertise and knowledge is relevant to the program. Once the Review Administrator collects information from all interested reviewers, they develop the Reviewer Matrix, a document that includes the specific and general expertise of all potential reviewers. This document is submitted to the Director of Grant Review for approval. Reviewers often have advanced degrees related to the mental health/prevention/treatment fields and decades of experience working in these fields with various populations in various settings. Many reviewers are affiliated with community-based organizations, universities, or state and local government public health authorities.

9. **Individuals with a serious mental illness often lack awareness of the existence of their illness. This serves as a common barrier to these individuals taking their medications or following their doctors' orders.**

    a. **What would you suggest be done if the patient in question refuses his or her doctor-prescribed medication?**

    Response: SAMHSA does not interfere in doctor/patient relationships and believes the patient's treatment team is in the best position to determine the appropriate treatment protocol. SAMHSA believes and supports the use of medications as one important approach to symptom management and to recovery. Therefore, SAMHSA has worked with physicians, other HHS operating divisions, and persons in recovery (often made possible with medications) to develop shared decision-making tools and practices as well as practice improvement toolkits (see also answers below to questions 1 and 2 from Representative Gingrey) to assist physicians and their patients work together to determine the best medication approaches for mental health conditions. Shared decision-making helps to assure understanding about the value of medications and medication compliance just as it does for other health conditions. Additionally, SAMHSA supports peer support and other approaches which often assist individuals to understand the role of medications in treatment and the importance of medication compliance. For those individuals with serious mental illness for whom medications are not effective or who do not choose to take medications (and are not legally required to do so), SAMHSA recommends assertive outreach and engagement efforts and practices that have shown promise in building relationships so that eventually individuals may be able to participate in treatment or services beneficial to them and their recovery.

b. **In such instances, do you think there is a role to be played by court-ordered outpatient treatment?**

Response: SAMHSA supports the treatment and recovery of persons with mental illness in the least restrictive environments and at the earliest possible opportunity. Waiting until someone is so sick they must be relieved of their rights and freedoms is the most costly and least effective practice. Focusing on early intervention and prevention of mental illness and/or the disabling effects of such illnesses can save millions of dollars in incarceration costs, allow people to work and earn a living and reduce the burden on families. Lowering the threshold to forced treatment may discourage Americans from seeking treatment. Therefore, SAMHSA supports treatment options that engage individuals with mental illness or mental health conditions to understand their health condition as much as possible and choose treatment and service options that will be acceptable to them. When a person cannot be engaged and will not participate in necessary treatment and meets criteria for involuntary treatment, SAMHSA agrees that such approaches may be necessary. Involuntary treatment criteria and laws are governed by states and state legislation.

10. **Prior to joining SAMHSA, and while serving as Cabinet Secretary for Human Services Department in New Mexico, you were already on the record opposing the introduction of AOT, along the lines of New York's Kendra's Law, in your state. You expressed this in a November 29, 2005 letter to the mayor of Albuquerque that you co-signed with Michelle Lujan Grisham, currently a Member of Congress from New Mexico's 1st District.**

a. **Among your representations at the time were that "seeking an AOT law at this time would seriously divide our behavioral health community...Any discussion of forced treatment will create division and controversy." How do you reconcile your position with respect to New Mexico with the very favorable view of AOT expressed to then-Secretary Grisham at about the same time by the Commissioner of the New York State Office of Mental Health? For example, the Commissioner reported to your office that as a result of AOT, rates tor hospitalizations, homelessness, arrests and incarcerations declined dramatically in New York.**

Response: I expressed concern about the *timing and impact* of the proposed New Mexico legislation, as indicated in the quoted statement. The proposed law had not been discussed with New Mexico behavioral health stakeholders before it was initially introduced, including the judges that would have to implement the law.

Involuntary treatment is governed by states and state legislation. As indicated at the hearing, AOT can be an effective model when accompanied by sufficient financial resources to ensure that appropriate treatment services are available to individuals that are court-ordered to receive outpatient treatment. The AOT law in New York was in a state with one of the highest per capita spending for mental health services and in addition was accompanied by a significant increase in state funding for mental health treatment services, and later funding was provided to do an extensive evaluation of New York's law. No such funding was included in the proposed New Mexico AOT legislation, even though New Mexico at the time had one of the lowest per capita spending rates in the country.

11. **In December 2011, SAMHSA announced a new working definition of "recovery" from mental and substance use disorders. Recovery is defined as "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."**

    a. **Is "Recovery," defined as such, an appropriate course of treatment for the 11 million Americans SAMHSA counts as having a serious mental illness? Is a self-directed life possible or indeed optimal for everyone, if it means individuals will go off their doctor-prescribed medications?**

    Response: SAMHSA does not define "Recovery" as a course of treatment but as a process and an outcome of better health, which can be accomplished through a number of clinical interventions and recovery supports, tailored to a person's individual needs. Medication is an important part of managing symptoms and hence the path to recovery for many persons with mental illness. Recovery can be viewed as a process by which an individual learns to manage his/her condition and lead a productive life and is facilitated by working with providers via medications, counseling, rehabilitative services, stress and relapse management, and other services and supports. The concept of recovery is for all individuals who are in process of improving their health care condition - including mental illnesses - at any stage of that condition. It does not negate the fact that a mental illness or an addiction can be a chronic or life-long condition. For too long, we have assumed as a society that persons with mental illness have a limited future and little to contribute. SAMHSA believes in recovery, with the key factor of hope that people can overcome their illnesses and live healthy, full and productive lives. Just as with other health conditions, medication is often a key part of that positive outcome, but it is unfortunately not effective for everyone or for every mental health condition.

    SAMHSA's role is not limited to certain mental illnesses or a small number of mental health conditions. Rather, SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities. Thus, SAMHSA is concerned about all Americans, whether they are in need of prevention or whether they are facing mild, moderate, or serious and persistent mental health issues. SAMHSA does not support only one approach to treatment for persons with mental health and addiction issues. SAMHSA supports individuals with mental illness and persons with addiction receiving the best available medication as well as other treatments and services they need to help them on the path to recovery. SAMHSA also supports additional research to improve the availability of effective medications and other treatments and services for all mental health conditions.

    Recovery is a process, not a treatment or an end state. Recovery is the goal of improved health and a productive life without addiction and without the disabling impacts of mental illness and is important to anyone with a health care problem at any stage.

12. **What is the basis for SAMHSA's strong commitment to "peer mentoring" and "peer support" approaches to "Recovery"?**

    a. **Is SAMHSA operating on the basis of any specific study which shows that peer support is more effective than the support of licensed mental health professionals?**

    Response: SAMHSA is not operating from a position that peer support is more effective than the support of licensed mental health professionals. SAMHSA's inclusion of peer support as an evidence-based practice is based on the demonstrated outcomes of numerous studies.[1] Peer support services usually operate in conjunction with other clinical services which amplify the benefit of treatment by offering ongoing support and psychosocial rehabilitation. Many peer support services require that they be part of a treatment plan authorized by a "licensed practitioner of the healing arts" such as a psychiatrist, psychologist, or physician in order to be reimbursed by Medicaid under Centers for Medicare & Medicaid Services (CMS) rules. Peer support services are a valuable adjunct to traditional care that are known to contribute to improved outcomes in employment, education, housing stability, satisfaction, self-esteem, medication adherence and decrease the need for more costly services, such as hospitalizations.

    The Department of Veterans Affairs (VA) has also recognized the value of peer supports and has a goal of hiring 800 peer support specialists representing people who are Veterans and who have successfully recovered from mental health conditions.

    b. **How much money, in the form of grants – either formula (including block grants) or competitive – does SAMHSA provide on an annual basis for programs whose primary treatment model is based around peer mentoring or peer support?**

    Response: SAMHSA does not directly fund any program operations whose primary treatment model is based around peer mentoring or peer support. SAMHSA promotes peer support services in behavioral health as effective, evidence-based practices mostly by providing technical assistance. As directed by Congress through appropriations legislation, SAMHSA funds the Consumer and Family State Network Grants (FY 2013 at $6.1 million for approximately 44 new grants, 17 grant continuations, and a technical assistance center) that promote peer-to-peer support and family-to-family support, and the Consumer and Consumer Supporter Technical Assistance Centers (FY 2013 at $1.9 million for five grants) that also provide information about peer support. SAMHSA also supports the Recovery Community Services Program for peers with addiction issues to prevent relapse and promote long-term recovery (FY 2013 at $2.4 million for five grants and two supporting contracts).

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[1] See a review of the evidence at http://store.samhsa.gov/shin/content//SMA11-4633CD-DVD/TheEvidence-COSP.pdf.

The President's FY 2014 Budget includes $50 million for workforce activities to help train more than 5,000 additional professionals to work with students and young adults with mental illnesses and other behavioral health problems. The proposal includes $35 million for a jointly-administered activity with HRSA to expand the Mental and Behavioral Health Education and Training (MBHET) Grant Program, $10 million for SAMHSA's Peer Professionals training program, and $5 million to expand SAMHSA's Minority Fellowship Program as described below. The Peer Professionals Workforce Development program would strengthen the behavioral workforce by increasing the number of trained peers, recovery coaches, mental health/addiction specialists, prevention specialists, and pre-Master's level addiction counselors working with an emphasis on youth ages 16-25.

13. What is the vetting process that SAMHSA uses before a given mental health intervention qualifies for inclusion in the National Registry of Evidence-based Programs and Practices (NREPP)? What are NREPP's minimum requirements for review? Who performs these reviews? How does NREPP define "evidence-based"?

Response: The National Registry of Evidence-based Programs and Practices (NREPP) is a voluntary, self-nominating system in which intervention developers elect to participate. There will always be some interventions that are not submitted to NREPP, and not all that are submitted are reviewed.

As outlined in "Announcement for the National Registry of Evidence-Based Programs and Practices: Open Submission Period for Fiscal Year 2014" (78 Fed. Reg. 33,854) for an intervention to be eligible for review, the submitter must provide written documentation that demonstrates the following minimum requirements have been met:

1) The intervention has produced one or more positive behavioral outcomes ($p \leq .05$) in mental health or substance abuse among individuals, communities, or populations. Significant differences between groups over time must be demonstrated for each outcome.

2) Evidence of the positive behavioral outcome(s) has been demonstrated in at least one study using an experimental or quasi-experimental design. Experimental designs include random assignment of participants, a control or comparison group in addition to the intervention group, and pre- and post-test assessments. Quasi-experimental designs include a control or comparison group and pre-and post-test assessments but do not use random assignment. Studies with single-group, pre-test/post-test designs do not meet this requirement.

3) The results of these studies have been published in a peer-reviewed journal or other professional publication (*e.g.*, a book volume) or documented in a comprehensive evaluation report. Comprehensive evaluation reports must include the following sections or their equivalent: a review of the literature, theoretical framework, purpose, methodology, findings/results (with statistical analysis and p values for significant outcomes), discussion, and conclusions. Information must be included to

enable rating of the six Quality of Research criteria: (1) reliability of measures, (2) validity of measures, (3) intervention fidelity, (4) missing data and attrition, (5) potential confounding variables, and (6) appropriateness of analysis.

4) Implementation materials, training and support resources, and quality assurance procedures have been developed and are ready for use by the public.

The documentation demonstrating these minimum requirements must be provided at the time of submission.

Once an intervention has been accepted for review, the developer and NREPP staff work together to identify the outcomes and materials to be used in the review. A review generally takes several months to complete, from the initial scheduling of the kick-off call to the completion of an NREPP intervention summary. NREPP staff identifies the reviewers who will participate in the review.

- NREPP staff sends review packets to two pairs of reviewers. One pair of reviewers focuses on Quality of Research, while the other pair looks at Readiness for Dissemination.
- Each of the reviewers independently reviews the materials provided and calculates ratings using the predefined Quality of Research and Readiness for Dissemination review criteria.
- The reviewers submit their ratings to NREPP.
- If their ratings differ by a significant margin, NREPP staff may hold a consensus conference to discuss and resolve the differences.

With respect to Quality of Research, each reviewer independently evaluates the Quality of Research for an intervention's reported results using the following six criteria (links below are to the NREPP website which will provide additional information):

1) Reliability of measures[2]
2) Validity of measures[3]
3) Intervention fidelity[4]
4) Missing data and attrition[5]
5) Potential confounding variables[6]
6) Appropriateness of analysis[7]

Reviewers use a scale of 0.0 to 4.0, with 4.0 being the highest rating given.

With respect to criteria for rating Readiness for Dissemination, each reviewer independently

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[2] http://www.nrepp.samhsa.gov/ReviewQOR.aspx#ROM.
[3] http://www.nrepp.samhsa.gov/ReviewQOR.aspx#VOM.
[4] http://www.nrepp.samhsa.gov/ReviewQOR.aspx#FID.
[5] http://www.nrepp.samhsa.gov/ReviewQOR.aspx#MDA.
[6] http://www.nrepp.samhsa.gov/ReviewQOR.aspx#PCV.
[7] http://www.nrepp.samhsa.gov/ReviewQOR.aspx#ANA.

evaluates the intervention's Readiness for Dissemination using the following three criteria (with links to the NREPP website for each):

1. Availability of implementation materials[8]
2. Availability of training and support resources[9]
3. Availability of quality assurance procedures[10]

Reviewers use a scale of 0.0 to 4.0, with 4.0 being the highest rating given.

All NREPP reviewers are recruited, selected, and approved by SAMHSA based on their experience and areas of expertise. The reviewer qualifications required for Quality of Research and Readiness for Dissemination differ because of the different kinds of expertise needed for these two areas. Once approved by SAMHSA, reviewers participate in at least 2 hours of training on the procedures and criteria they will use to rate interventions. Reviewers are paid for their participation in the training as well as any preparation time. Training is typically done via web conferencing. Reviewers are required to sign a Conflict of Interest disclosure statement for each intervention they review, to ensure they have no professional ties or financial or other interests in the intervention that could prevent an objective review.

SAMHSA does not assign reviewers to specific interventions. Instead, assignments are made by NREPP contract staff. Interventions are matched with reviewers having appropriate qualifications and the most relevant experience and content knowledge. The identity of reviewers assigned to reviews is kept confidential from both SAMHSA and the applicant.

Quality of Research reviewers must possess:

- A doctoral-level degree; and
- A strong background and understanding of current methods of evaluating prevention and treatment interventions.

In addition, candidates who have direct experience providing prevention and/or treatment services are preferred.

Readiness for Dissemination reviewers are selected from two categories: direct service experts (including both providers and consumers of services), or experts in the field of implementation.

For direct service experts, the minimum qualifications include:

- Previous experience evaluating prevention or treatment interventions; and
- Knowledge of mental health or substance abuse prevention or treatment content areas.

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[8] http://www.nrepp.samhsa.gov/ReviewRFD.aspx#Materials.

[9] http://www.nrepp.samhsa.gov/ReviewRFD.aspx#Training.

[10] http://www.nrepp.samhsa.gov/ReviewRFD.aspx#QA.

For implementation experts, the minimum qualifications include:

- Previous experience implementing interventions, doing evaluation work in service settings, and/or conducting research across interventions; and
- Knowledge of mental health or substance abuse prevention or treatment content areas.

The Honorable Marsha Blackburn

1. **Please submit to the Committee your complete remarks, as delivered at the 2012 Alternatives Conference. If not transcribed, please provide the Committee with a videotape of your remarks.**

   Response: The remarks were not transcribed or videotaped.

2. **When did SAMHSA begin sponsoring the Alternatives Conferences?**

   Response: SAMHSA began sponsoring the conference when the Agency was formed in 1992.

3. **How much money have you spent on Alternatives Conferences in 2012, and in all prior years?**

   Response: SAMHSA spent a total of $165,373 FY 2012 funds for the Alternatives Conference. This cost includes grant supplement, consumer scholarships, speaker fees, and Federal travel.

   SAMHSA provided the following dollar amounts via grants to facilitate the planning of the Alternatives conference in previous years. These amounts do not include the amount of consumer scholarship support which in general averages around $30,000 each year to ensure that approximately 30 people with mental illnesses can attend the conference.

FY 2012:	$127,000
FY 2011:	$127,000
FY 2010:	$127,000
FY 2009:	$126,000
FY 2008:	$124,000

4. **How much money has SAMHSA spent on conferences in general?**

   Response: As reported in the HHS report on FY 2012 conference spending, which is required by Office of Management and Budget Memorandum M-12-12, SAMHSA held 17 conferences over $100,000 each between February and September 2012, for an aggregate cost of $6,666,696.[11] FY 2012 was the first year that this information was collected and reported, and not all conferences and their costs were able to be included. SAMHSA expects the reporting in FY 2013 and beyond will be more complete due to the ongoing implementation of the reporting requirements of M-12-12, and now section 3003 of the

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[11] http://www.hhs.gov/open/recordsandreports/conference_spending_full.pdf.

Consolidated and Further Continuing Appropriations Act, 2013. Please note that the 2012 Alternatives conference was held in October 2012, and was therefore not included in the FY 2012 report.

In the first three quarters of FY 2013, SAMHSA estimates it will spend $5 million on conferences, a 40 percent savings of $3.5 million below the previously projected conference costs of $8,478,132.

5. **What is the breakdown of money that you have spent on speakers you have had at these conferences and the scholarships that you have given?**

   Response: In FY 2012, $29,848 was paid for travel, lodging and registration for 28 consumers to attend the Alternatives Conference. The only scholarships provided by SAMHSA in FY 2012 were for the Alternatives Conference. For the 17 conferences that SAMHSA held from February to September 2012 that cost over $100,000, $51,743 was spent on speaker costs.

6. **How much did SAMHSA pay for the painting it commissioned of Sam English, as referenced in SAM HSA's newsletter from March/April 2011?**

   Response: SAMHSA paid Mr. English $8,500 for the painting.

The Honorable Phil Gingrey

1. **The Director of the National Institute of Mental Health, Thomas Insel, M.D., testified before this Subcommittee on March 5, 2013, "that effective treatments, which include medication adherence and evidence-based psychosocial therapy, can reduce the risk of violent behavior fifteen-fold in persons with serious mental illness." We also heard at the Hearing multiple testimonies on the importance of medication adherence and the tragic consequences that can follow when a person with a serious mental illness stops taking his or her prescribed anti- psychotic medications. Given the importance of medication adherence, please provide a report on what materials and information, for patients, families and treatment professionals, SAMHSA has created and disseminated, that address the importance of medication adherence for serious mental illness.**

   Response: SAMHSA has 11 Evidence–Based Practices (EBP) Knowledge Informing Transformation (KIT) products which address various aspects of providing behavioral health evaluation and treatment for children, adults with serious mental illness and older adults. All SAMHSA's EBP KITs support adherence to medication regimes along with patient-centered treatment approaches. Implicit in this approach is for psychiatrists or other physicians who prescribe medications for patients with mental or substance use disorders to work with the patient to determine the best type and schedule of medication which will enable the person to function at the highest level. The KITs describe various types of psychosocial treatment modalities in detail which complement medication management.

   The Medication, Treatment, Evaluation, and Management (MedTEAM) EBP KIT[12] is a specific KIT for psychiatrists and other prescribing physicians that provide guidance on EBPs related to medication management for clients/consumers with mental disorders. MedTEAM offers agencies, and the systems in which they participate, guidance on developing a systematic approach to medication management. The approach includes developing a plan to keep up with the evidence about medications, including using treatment guidelines or algorithms to inform medication decisions.

   The Illness Management and Recovery EBP KIT[13] promotes using medications more consistently. The KIT provides practical handouts and class session descriptions which include training on how to use medications as prescribed by the psychiatrist.

   Other EBP KITs in the series are:

   - Family Psychoeducation;
   - Integrated Treatment for Co-Occurring Disorders;
   - Assertive Community Treatment;
   - Intervention for Disruptive Behavior Disorders;

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[12] http://store.samhsa.gov/product/MedTEAM-Medication-Treatment-Evaluation-and-Management-Evidence-Based-Practices-EBP-KIT/SMA10-4549

[13] http://store.samhsa.gov/product/Illness-Management-and-Recovery-Evidence-Based-Practices-EBP-KIT/SMA09-4463

- Consumer Operated Services;
- Permanent Supportive Housing;
- Evidence-Based Treatment for Depression in Older Adults; and
- Supported Employment;
- Supported Education: A Promising Practice.[14]

2. **In our own effort to find materials that SAMHSA has produced and made available to the public and professionals on the topic of anti-psychotic medications, we were able to find only two publications[15] [16]Of these two publications, neither of them made mention of the medications that are specifically formulated to address the problem of non-adherence-that is, long-acting injectable antipsychotic medications. Since long-acting antipsychotic medications have been available for more than 10 years, and provide a reliable way of certifying that patients with serious mental illness are receiving their medication, what plans does SAMHSA have for helping the public and professionals learn about these antipsychotic medications?**

   Response: As described above, the MedTEAM EBP Kit equips treatment teams at mental health agencies with a systematic plan to ensure they use the latest scientific evidence coupled with patient input in making medication management decisions for people with mental illnesses. The KIT recognizes that the key to a client's adherence to medication therapy is their active participation and involvement in shared decision making. When clients understand and participate in their treatment regimen, they are more likely to adhere to the plan and take medication as prescribed.

   SAMHSA has created an interactive decision aid on the use of antipsychotic medications that helps providers and patients choose which antipsychotic medications work best for the individual. Although the decision aid does not specifically mention long-acting injectable delivery systems for antipsychotic medications, the intent of the decision aid is for the provider and patient to review what works best when taking antipsychotic medications and how they are delivered would be a component of that conversation. The decision aid also helps them consider services and a variety of wellness activities as part of an overall recovery plan. Also available are a series of one-page, downloadable tools that include worksheets, a medication side effect checklist, questions to ask about recommended medications, and conversation starters. A companion workbook titled, *Supporting Choice: Helping Someone Make an Important Decision*, is designed to help a supporter guide a person through the process of making decisions about antipsychotic medications.

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[14] See http://store.samhsa.gov/list/series?name=Evidence-Based-Practices-KITs.

[15] Substance Abuse and Mental Health Services Administration. *Interventions for Disruptive Behavior Disorders: Medication Management*. HHS Pub. No. SMA-11-4634, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2011.

[16] Substance Abuse and Mental Health Services Administration. *Shared Decision Making in Mental Health Decision Aid Considering the Role of Antipsychotic Medications in your Recovery Plan.* April 2012.

The following list is a sample of publications distributed by SAMHSA that discuss the use of antipsychotic medications in the treatment of behavioral health conditions:

- Community Conversations About Mental Health: Information Brief;[17]
- Illness Management and Recovery: Practitioner Guides and Handouts;[18]
- Integrated Treatment for Co-Occurring Disorders: Training Frontline Staff;[19]
- Interventions for Disruptive Behavior Disorders: Medication Management;[20]
- Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs In-service Training;[21]
- MedTEAM: Training Frontline Staff;[22]
- Substance Abuse Treatment for Persons With Co-Occurring Disorders;[23]
- SAMHSA's Wellness Initiative: Information for General Health Care Providers;[24] and
- What is Right for Me? Considering the Role of Antipsychotic Medications in My Recovery Plan.[25]

3. **When an individual suffers from both schizophrenia and alcohol dependence, research has shown that they are at much greater risk for violent behavior. Over one-third of patients with schizophrenia also have a drinking problem, and the prevalence of alcohol dependence among individuals with schizophrenia is several times greater compared to the general population. Even without the added challenges of serious mental illness, alcohol dependence is strongly associated with violence and crime. In an analysis conducted by the Department of Justice, a third of all criminal offenses were alcohol-related and nearly 40% of all violent offenses were alcohol-related. As with antipsychotic medications, the problem of non-adherence is a major issue for alcohol dependent individuals. The negative impact of non-adherence on the orally-dosed alcohol dependence treatment medications is notorious and extensively well-documented in general (also see: oral naltrexone, acamprosate and disulfiram), and is correlated with increased healthcare costs. Quite simply, medications do not work if they are not taken. Given the role that excessive alcohol use plays in violent crime, and crime in general, as well as its impact on people with serious mental illness and on health, please describe what initiatives SAMHSA is funding to encourage the use of FDA-approved medications in the treatment of alcohol dependence and whether and how the issue of non-adherence with these medications is being addressed.**

   Response: SAMHSA has produced and disseminated a Treatment Improvement Protocol (TIP), "Incorporating Alcohol Pharmacotherapies into Medical Practice,"[26] along

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[17] http://store.samhsa.gov/shin/content//SMA13-4763/SMA13-4763.pdf.

[18] http://store.samhsa.gov/shin/content/SMA09-4463/PractitionerGuidesandHandouts.pdf

[19] http://store.samhsa.gov/shin/content/SMA08-4367/TrainingFrontlineStaff-ITC.pdf

[20] http://store.samhsa.gov/shin/content/SMA11-4634CD-DVD/MedicationManagementChild-IDBD.pdf

[21] http://store.samhsa.gov/shin/content//SMA09-4341/SMA09-4341.pdf

[22] http://store.samhsa.gov/shin/content//SMA10-4549/TrainingFrontlineStaff-MT.pdf

[23] http://www.ncbi.nlm.nih.gov/books/NBK64197/pdf/TOC.pdf

[24] http://store.samhsa.gov/shin/content//SMA12-4566/SMA12-4566.pdf

[25] http://162.99.3.211/sdm/DA_files/index.html

[26] http://162.99.3.213/products/manuals/tips/pdf/TIP49.pdf.

with a series of related publications.[27] The TIP covers each of the FDA-approved medications for treating alcohol use disorders and addresses pretreatment indicators, including risk factors for poor medication adherence. SAMHSA has also released a Substance Abuse Treatment Advisory, "Naltrexone for Extended-Release Injectable Suspension for Treatment of Alcohol Dependence."[28]

Research evidence supports that pharmacotherapy combined with psychotherapy is more effective than deploying either intervention alone. SAMHSA's NREPP features one such intervention for alcohol treatment. Broad Spectrum Treatment (BST) and Naltrexone for Alcohol Dependence is a three-to-six-month program that uses manual-guided cognitive behavioral therapy in combination with naltrexone pharmacotherapy (50mg daily) to treat adults with alcohol dependence. BST therapists deliver eight to 14 individual sessions incorporating components of motivational enhancement therapy community reinforcement, and 12-step approaches

SAMHSA's Addiction Technology and Transfer Centers communicate considerable information to the field about alcoholism and the medications used to combat this problem. They conduct training and provide resources regarding medication management and adherence, including a training PowerPoint on medication management and adherence.[29]

4. **In your testimony before us on May 22, 2013 you stated that much of SAMHSA's funding goes to the block grants, which are passed on to States to fund substance abuse treatment - which is well over $1 billion. We understand that a significant portion of addicted individuals relapse to drug use. Further, we understand that, for the treatment of opioid dependence, SAMHSA dedicates a great deal of funding, time and effort on the development and delivery of education and training activities with respect to substitution, or replacement therapies – medicines which can be diverted, traded, sold, smuggled and/or abused. Is it within the authority of SAMHSA to provide stronger guidance to States to use some percent of their block grant funds on FDA-approved non-addictive medications?**

   Response: The authorizing statute for the Substance Abuse Prevention and Treatment Block Grant (SABG) does not provide SAMHSA the authority to direct states to dedicate a percentage of their SABG funds to the use of specific types of medications. However, states have the flexibility to implement evidence-based practices that meet the needs of their respective jurisdictions and the use of interventions such as naltrexone combined with psychotherapy to treat opioid dependence have been highlighted in SAMHSA's consultations with state authorities as promising practices. As indicated above, SAMHSA also provides guidance through the Addiction Technology and Transfer Centers,

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[27] See Quick Guide for Physicians Based on TIP 49 at http://store.samhsa.gov/shin/content//SMA10-4543/SMA10-4543.pdf; Quick Guide for Counselors Based on TIP 49 at http://store.samhsa.gov/shin/content//SMA10-4542/SMA10-4542.pdf; and KAP Keys for Clinicians Based on TIP 49 at http://store.samhsa.gov/shin/content//SMA10-4544/SMA10-4544.pdf.

[28] http://162.99.3.213/products/manuals/pdfs/naltrexone.pdf.

[29] See http://www.attcnetwork.org/find/news/attcnews/epubs/addmsg/august2012article.asp and http://www.attcnetwork.org/learn/topics/alcoholism/treatment_medications.asp.

publications, and training activities.

5. **Since the inception of the Medicaid program in 1965, inpatient psychiatric services provided in an IMD (Institution for Mental Disease) have been excluded from federal matching funds. This policy has been maintained over time in order to prevent federal Medicaid funds from financing long-term state psychiatric hospitals. However, in many States, this Medicaid IMD exclusion still serves as a huge barrier to the availability of acute inpatient treatment. In many communities across Georgia and the nation, the acute inpatient psychiatric bed capacity has reached dangerously low levels, creating a genuine access crisis for emergency mental health services.**

    a. **Has SAMHSA compiled any data on the lack of acute inpatient bed capacity and its consequences in terms of the burden placed on hospital emergency rooms, law enforcement and homeless services that you can share with the Subcommittee?**

    Response: SAMHSA routinely reports the number of state psychiatric hospital beds available in its publication series *Mental Health, United States*. For more than 25 years, the *Mental Health, United States* series has presented nationwide measures of mental health. Published biannually by SAMHSA, the volume serves as the Nation's most comprehensive resource for mental health statistics. The data provide timely insights into the population's mental health status, the provision of mental health treatment, and funding for that treatment in the United States.[30]

    In addition, *Mental Health, United States, 2010* (Table 46) reported that the number of mental health organizations with 24-hour hospital/residential treatment settings (including all types of organizations) decreased from 3,039 in 1986 to 2,891 in 2004. The number of beds per 100,000 civilian population in these organizations went from 111.7 in 1986 to 71.2 in 2004.[31]

    SAMHSA reported in *Mental Health United States 2010* (Tables 113, 114, and 115) that in 2007 there were 232,636 psychiatric beds in state and local hospitals, beds in other state and local hospitals, private psychiatric hospital beds, and in all General Hospital psychiatric beds.

    In addition to the number of psychiatric hospital beds, SAMHSA has highlighted approaches to comprehensive crisis services in order to help prevent the need for emergency room visits and/or psychiatric inpatient services. These include: the development of crisis service delivery system guide to establish services or expand on existing services and make them more effective; support and knowledge dissemination of effective crisis respite services to alleviate pressure on emergency rooms; and suicide response crisis services.

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[30] http://www.samhsa.gov/data/2k12/MHUS2010/MHUS-2010.pdf.
[31] http://www.samhsa.gov/data/2k12/MHUS2010/MHUS-2010.pdf.

In addition, SAMHSA is aware of the CMS demonstration project that is testing whether Medicaid programs can support higher quality care at a lower total cost by reimbursing private psychiatric hospitals for certain services for which Medicaid reimbursement has historically been available. The demonstration project was authorized by section 2707 of the Affordable Care Act. The demonstration provides states with Federal Medicaid matching funds to reimburse private psychiatric hospitals for emergency inpatient psychiatric care provided to Medicaid recipients aged 21 to 64 who are experiencing a psychiatric emergency.

The Honorable Morgan Griffith

1. **What is the total amount of money that SAMHSA has spent on tobacco programs annually over the last five fiscal years? How does this compare with the total funding for mentalhealth programs, including treatment, during that same time period?**

   Response: SAMHSA has spent the following on tobacco programs over the last five fiscal years:

   FY 2008: $36 million
   FY 2009: $37 million
   FY 2010: $38 million
   FY 2011: $38 million
   FY 2012: $38 million

   In comparison, SAMHSA has spent the following on mental health programs in CMHS over the last five fiscal years:

   FY 2008: $911 million
   FY 2009: $969 million
   FY 2010: $1,019 million
   FY 2011: $1,022 million
   FY 2012: $994 million

The Honorable Renee Elmers

1. **Is SAMHSA providing funding to organizations that support and promote taking away medical treatment for the mentally ill?**

   Response: None of SAMHSA's grants, cooperative agreements or contracts is for the purpose of supporting or promoting the denial of medical or other treatment for individuals with mental illness. SAMHSA only provides funding to organizations for the specific purposes of its grant, cooperative agreement and contract specifications, regardless of the views of the organization. Thus, no organizations are allowed to use SAMHSA funding for the purpose of supporting or promoting the denial of medical or other treatment for individuals with mental illness.

2. **What criteria do organizations have to meet before you would give them a grant, if they are supporting a treatment that is not something you would maintain is beneficial for treating mental illness?**

   Response: SAMHSA does not give grants for treatments or services that are not beneficial for treating mental illness or substance use disorders. However, most grantees have state or Federal grants or other non-governmental resources in addition to the funds provided by SAMHSA. In general, SAMHSA grants may be awarded to domestic public or private, non-profit or for-profit organizations. Some funds are designated by the Congress for certain entities (*e.g.,* states and territories, governor-designated entities such as PAIMI programs, or non-profits only in some cases). For example, 67 percent of SAMHSA grants are formula grants provided directly to States under SAMHSA's authorizing legislation. Other than these state formula grants, eligible organizations may include state, local, and tribal governments; institutions of higher education; other non-profit organizations (including faith-based, community-based, and tribal organizations); and hospitals. Eligibility for a particular funding opportunity announcement is specified in the Grants.gov FIND synopsis, with more detailed eligibility information found in the funding opportunity announcement. On the basis of a statute, regulation or a limitation, with appropriate justification, described in a funding opportunity announcement, SAMHSA may limit eligibility to, or exclude from eligibility, classes or types of entities. Examples are limitations on the participation of foreign entities, and programs under which only small businesses are eligible applicants.

   An example of linking formulary grant eligibility or acceptance criteria to outcomes can be found in the Community Mental Health Services Block Grant (MHBG). This key source of funding for community-based services for adults with serious mental illness and children with serious emotional disturbance is used by states, territories and one tribe (hereinafter, states) to provide a range of mental health services and system infrastructure and capacity support described in their Block Grant application plans. Prior to grant award, states must demonstrate capacity and ability to report on performance and outcome data. SAMHSA's reporting systems collect and report state performance data on MHBG service recipients. SAMHSA provides monitoring and technical assistance to ensure successful grantee performance and improved outcomes for adults with serious mental illness and children/youth with serious emotional disturbance.

On the discretionary grant side, SAMHSA's Primary and Behavioral Health Care Integration program links discretionary grant eligibility or acceptance criteria to outcomes by requiring grantees improve the physical health status of adults with serious mental illness. Grantees must work as integrated clinical service communities to coordinate and integrate primary care services into publicly funded community mental health and other community-based behavioral health settings. Prior to grant award, applicants must demonstrate capacity and ability to report on performance and outcome data. SAMHSA's reporting systems collect and report grantee performance data on discretionary grant requirements.

3. **What are the details of the application process for organizations that want to receive grants from SAMHSA?**

   Response: In order to maintain objectivity in the grant review process, all peer reviews for applications to programs supported by CMHS are performed by DGR. The peer review process is identical for all discretionary grant applications, regardless of the size or subject of award. Prior to submission to a peer review committee, every application is screened to ensure that basic eligibility requirements and program specific requirements as published in the RFA are met. Any applications that do not adhere to the administrative and programmatic eligibility screening requirements are screened out and not reviewed further.

   SAMHSA employs a rigorous process that treats all applications in a fair and equitable manner. Once an application clears the preliminary screening it is sent forward to a peer review committee. Each application is reviewed by three external reviewers who have been chosen because their expertise and education align with those identified as required to successfully implement the specific program. In addition to expertise, a concerted effort is made to include diversity in reviewer pools, therefore factors such as gender, ethnicity, and geographic location are considered but do not outweigh expertise.

   To ensure that all applications are reviewed in the same manner, peer reviewers are instructed to use the detailed assessment form created by DGR when scoring applications. The assessment form includes the detailed breakdown of all scored criteria from the specific program announcement. To ensure that reviewers are thorough and complete, reviewers must, for example, indicate the page number of the application where the response is found for each contributing factor. Reviewers must also write detailed comments for any criteria that they deem "Marginal" or "Unacceptable." Lastly, reviewers are asked to provide comments on the budget and participant protection elements of each application. While these two items are not scored, it still provides critical feedback for the applicants.

   Applications are then ranked in score order. In making funding decisions, SAMHSA utilizes this order ranking to determine a fundable range. Frequently SAMHSA receives more applications than it can fund. However, staff may consider other factors such as population focus and/or geographic distribution when determining awards and these factors are specified in the funding announcement. When this occurs, the justification for skipping applications is provided in the funding plan that is submitted to the Administrator.

The Honorable Henry A. Waxman

1. **Does SAMHSA use evidence-based approaches to identify how to prioritize its resources? Can you provide examples to the Committee?**

   Response: Both SAMHSA's discretionary and formula grant portfolios place significant importance on the use of evidence-based practices. Discretionary grant RFAs routinely include application criteria in which applicants must describe selecting, implementing, evaluating, and sustaining evidence-based practices as a requirement of the grant.

   Evidence-based programs form the basis of most key initiatives; a few examples include, but are not limited to, the National Children Traumatic Stress Initiative, Children's Mental Health Initiative, Homeless Prevention and Treatment for Homeless programs, Strategic Prevention Framework including the related Partnership for Success, Safe Schools/Healthy Students, and the Screening, Brief Intervention, and Referral to Treatment program. In addition, SAMHSA supports the advancement of evidence-based practices by disseminating key evidence based behavioral health resources such as TIPs, Technical Assistance Publications (TAPs), the NREPPs, and evidence-based toolkits to the mental health and substance abuse delivery system further facilitating practice improvement.

   For formula grants, the MHBG application encourages state grantees to purchase evidence-based practices. This focus and subsequent reporting to SAMHSA through the performance measurement system, has contributed to more effective treatment through evidence-based practices for adults with serious mental illness and children with serious emotional disturbance. Data indicate a continual growth in both the number of children receiving evidence-based practices and the number of evidence-based practices established, and the number of adults reported to receive evidence-based practices increased.

   The President's FY 2014 Budget proposes to work with states to use at least five percent of their MHBG funds to award competitive grants to implement the most effective evidence-based prevention and treatment approaches, focusing on promotion, prevention and early intervention. This new set-aside and focus would be used by states to demonstrate how both MHBG and other funding streams can be utilized in the changing funding and service delivery environment to have the most positive impact on the health and well-being of the persons and communities served through these set-aside awards.

2. **Dr. Fuller Torrey, a witness on the second panel, stated in his testimony to the Committee that mass killings conducted by people with serious mental illness is "not a priority for them SAMHSA at all." Is this accurate? What steps is the agency taking to combat this problem?**

   Response: This statement is not accurate. The Administration understands sometimes, particularly when untreated, mental illness can lead to suicide or a large-scale tragedy. Even for individuals with no likelihood of violence, untreated mental illnesses too often cause immense distress and can prevent people from living healthy, fulfilling lives. That's why the

President's gun-violence-reduction plan includes a new $130 million initiative at SAMHSA to address several barriers that sometimes prevent people from accessing help. This initiative proposes to help teachers and others interacting with young people recognize signs of mental illness in students and refer them to mental health services if needed, support innovative state-based programs to improve mental health outcomes for young people ages 16-25, and train 5,000 more mental health professionals to serve students and young adults. SAMHSA looks forward to congressional support for those initiatives.

At the same time, it is important to note that behavioral health research and practice over the last 20 years reveal that most people who are violent do not have a mental disorder, and most people with a mental disorder are not violent.[32] Studies indicate that people with mental illnesses are more likely to be the victims of violent attacks than the general population.[33] In fact, demographic variables such as age, gender and socioeconomic status are more reliable predictors of violence than mental illness.[34] These facts are important because misconceptions about mental illness can cause discrimination and unfairly hamper the treatment and recovery of the nearly 20 percent of all adult Americans who experience a mental illness each year.

In FY 2013, approximately 29 percent ($961.3 million) of SAMHSA's funding was appropriated to support mental health programs and activities, with the remainder directed to substance abuse programs and activities. As directed by Congress, of the SAMHSA mental health funding, most ($915.3 million) supports prevention, treatment and recovery support programs and activities within CMHS. Approximately 48 percent ($436.81 million) of CMHS funding is directed toward the Community Mental Health Services Block Grant, which provides services and supports for adults with serious mental illness and children with serious emotional disturbance. The balance of the CMHS budget (52 percent) provides support for a range of mental health prevention, treatment and recovery support services, also as directed by Congress. In FY 2013, approximately 81 percent of the CMHS budget will support adults with and at risk for serious mental illness and/or children with serious emotional disturbance. Within the CMHS budget over the last five years, 75-80 percent of appropriated funding has been used for mental health programs in support of adults with serious mental illness and children with serious emotional disturbance.

SAMHSA is extremely concerned about the violence perpetrated by and on persons with mental health conditions, and on the trauma that results from violent and mass casualty events, whether due to a weather related event, a man-made event, or the act of a person with mental illness or more often of persons with hate, terrorism, domestic violence, or other criminal intent. SAMHSA plays a critical role in the response to mass casualty events through its Disaster Technical Assistance Center, its Disaster Distress Helpline, its first responder training and disaster preparedness and response materials. SAMHSA also plays a

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[32] Monahan J, Steadman H, Silver E, et al: Rethinking Risk Assessment: The MacArthur Study of Mental Disorder and Violence. New York, Oxford University Press, 2001 and Swanson, 1994.

[33] Appleby, L., Mortensen, P. B., Dunn, G., & Hiroeh, U. (2001). Death by homicide, suicide, and other unnatural causes in people with mental illness: a population-based study. *The Lancet*, 358, 2110-2112.

[34] Elbogen EB, Johnson SC. Arch Gen Psychiatry. 2009 Feb;66(2):152-61. doi: 10.1001/archgenpsychiatry.2008.537. The intricate link between violence and mental disorder: results from the National Epidemiologic Survey on Alcohol and Related Conditions.

leadership role in addressing the primary violence that occurs by and against persons with mental health conditions, which are self-inflicted suicide attempts or death by suicide. In addition, SAMHSA staff members are active participants in the Nation Forum on Youth Violence Prevention.

SAMHSA also plays a critical role in helping states and communities address the impact of trauma through its National Child Traumatic Stress Initiative. SAMHSA is also working closely with the White House, with other operating divisions within HHS, and with other Federal agencies such as VA and the Departments of Education, Justice, and Defense (DOD), to identify ways to identify individuals with untreated behavioral health needs and build the capacity in communities, families and primary care settings to recognize and refer to treatment such individuals earlier in order to prevent negative outcomes for individuals and their families. The President's FY 2014 Budget proposes additional approaches in which SAMHSA will be able to reduce negative attitudes and increase mental health literacy so individuals with mental health needs and their families do not go unnoticed or become isolated without adequate treatment and support. For example, Project AWARE (Advancing Wellness and Resilience in Education) would increase awareness of mental health issues and connect young people with behavioral health issues and their families with needed services. Project AWARE State Grants ($40 million) would build on the Safe Schools/Healthy Students State Planning and Community Pilot Program, which is intended to create safe and supportive schools and communities. The second component, Mental Health First Aid (MHFA) ($15 million), proposes widespread dissemination of the MHFA curriculum and supports training to reach 750,000 students to identify mental illness early and refer them to treatment. In addition, the President's FY 2014 Budget includes $25 million for a new Healthy Transitions Program, to assist 16 to 25 year-olds with mental illnesses and their families to access and navigate behavioral health treatment systems. SAMHSA looks forward to congressional support for those initiatives.

3. **Dr. Fuller Torrey posited in his written testimony that "SAMHSA spends millions of dollars supporting programs which actively oppose effective treatments; funds an annual anti-treatment national conference; is more concerned about psychiatric bed availability in Iraq than in the U.S.; produces picture books for children; commission's paintings ($22,500); and holds an annual staff musical ($80,000)." Are these statements accurate? Can you provide context on the allegations made by Dr. Torrey?**

Response: These statements are not accurate. SAMHSA does not fund programs that actively oppose effective treatment for mental illnesses. SAMHSA does not fund an annual anti-treatment national conference. SAMHSA is not more concerned about psychiatric beds in Iraq than in the United States.

Dr. Torrey has inaccurately referred to the Alternatives Conference as an anti-treatment annual conference. The purpose of the Alternatives Conference since first funded in 1985, seven years before SAMHSA's establishment, is to provide a forum for individuals with serious mental illnesses from all over the nation to meet, to exchange information and ideas, and to provide and receive technical assistance through hands-on skill-building, knowledge development and knowledge application on topics such as effective treatments and supports (including medications, and evidence-based practices) and complementary services such as recovery supports and peer-support services reimbursed by Medicaid. SAMHSA's grant funding would not imply endorsement of an organization's policy positions in any case, but neither would SAMHSA provide funding to support any meeting or conference that is against treatment for mental or substance use disorders.

With regard to the allegations about Iraq, SAMHSA began providing technical assistance in 2004 to Iraq's Ministry of Health in its efforts to rebuild Iraq's mental health services sector. Such support included two conferences, one in 2005 and one in 2006 and two visits to various United States host sites by teams of Iraqi behavioral health professionals in 2008 and 2010. Discussions about availability of psychiatric beds in Iraq took place at the two conferences, at which SAMHSA provided input on a variety of behavioral health system issues ranging from the development of community-based services to institutional care.

SAMHSA has produced a handful of picture books for very young children because according to scientific evidence it is more effective to communicate with very young children via picture books and visuals to help them understand mental health and help them recover from traumatic experiences. Age-appropriate intervention tools explain the importance of mental health and demonstrate ways to appropriately express feelings relevant to the age group (the coloring books are a good example of how a young child can learn about mental health and emotions).

American Indian/Alaska Native (AI/AN) populations have indicated a desire for materials and information produced by AI/AN individuals and sensitive to AI/AN values and traditions. In 2010, SAMHSA engaged a Native American artist who is a person in recovery from alcoholism and depression and who has created images and posters for Native American substance abuse and other health and human services programs throughout the country. This individual, just as any graphic artist assisting with materials development, produced an original image in the form of a painting from which he printed posters including SAMHSA's phone number and website for information about behavioral health and ways to find treatment, as well as positive behavioral health messages. Mr. English also helped launch the public awareness effort at a small event at the SAMHSA building involving SAMHSA employees and representatives from the Indian Health Service as well as other HHS agencies. The posters were ultimately disseminated to tribal leaders throughout the country to post in their facilities and use in their programs and to individuals requesting the posters through SAMHSA's online store.

SAMHSA staff is comprised of dedicated, creative and passionate professionals who care deeply about the issues they work on each day. To provide information about SAMHSA's programs, services, and issues and keep staff up to date on issues in the field, staff members sometimes conduct in-service trainings for their colleagues using experts in SAMHSA or other agencies. This process helps provide information for SAMHSA staff and for interested stakeholders and individuals in the field. SAMHSA's direct costs for this production were approximately $7,000 for set support and sound.

Was the artwork painted by Sam English used as the basis for outreach materials? If so, how many tribes received the outreach materials on the topic of mental health? What value did these outreach materials play with regard to achieving a successful outcome for this program?

Response: Yes, as outlined above, the artwork was used as the basis for outreach materials to the AI/AN community. SAMHSA has provided the posters, which include the image of an AI/AN community, ways to obtain information on behavioral health issues by listing SAMHSA's phone number and website, as well as positive behavioral health messages, to representatives of Federally-recognized tribes and tribal organizations who have requested the posters or who attended various tribal consultation events. The value added by the outreach materials is that culturally-appropriate public awareness materials were made available to reach the AI/AN population which responds best to materials and information produced by AI/AN individuals and sensitive to AIAN values and traditions. Data from SAMHSA's National Survey on Drug Use and Health show that AI/AN individuals were more likely than persons from other racial/ethnic groups to have needed treatment for alcohol or illicit drugs in the past year and that the percentage of adults aged 18 or older having serious thoughts of suicide in the past year was 13.1 percent. These data show the importance of reaching the AI/AN population in order to ensure that they receive treatment for behavioral health issues.

4. **Dr. Torrey's statement referred to the Vice President's Task Force on Gun Violence. He stated:**

> **To support the SAMHSA position it invited a psychiatrist, Dr. Daniel Fisher, to testify before the Biden Task Force. SAMHSA had to invite an outside psychiatrist because it has nobody among its 574 staff who has expertise on severe mental illness.... Dr. Fisher stated categorically to the Task Force that mental illness and violence are not linked, an assertion that is contradicted by more than 20 studies. Dr. Fisher, whose organization receives $330,000 each year from SAMHSA, is unusual in his belief that schizophrenia is not a disease of the brain, an assertion that is contradicted by literally hundreds of studies.... Rather Dr. Fisher describes the condition called schizophrenia as "severe emotional distress" or "a spiritual experience." This is apparently consistent with SAMHSA's position.**

Please comment on the role of SAMHSA on the Vice President's Task Force, and on the accuracy of the statements above.

Response: Dr. Torrey's statements related to the expertise of SAMHSA staff on the topics of adults with serious mental illness and children with serious emotional disturbance are inaccurate. Dr. H. Westley Clark, M.D., J.D., M.P.H., CAS, FASAM, is an expert in serious mental illness and has previously served as an associate clinical professor, Department of Psychiatry, University of California at San Francisco. In addition, SAMHSA's National Advisory Council includes experts in serious mental illness and serious emotional disturbance including Dr. Stephanie Le Melle, Dr. Donald E. Rosen, and Dr. Benjamin F. Springgate.

SAMHSA of course recognizes that schizophrenia is one of many diagnoses listed in the DSM-5, and is a serious mental illness. However, SAMHSA's statutory authority and mission do not permit the agency to limit its focus to only those individuals who experience specific diagnoses in the DSM-5.

SAMHSA's role in the Vice President's Task Force on Gun Violence was to provide expertise on the issues of mental health promotion and early intervention, as well as on the state of the mental health workforce. Proposals related to reducing the impact of mental illness on America's communities were included in the President's Now is the Time plan. SAMHSA recommended potential meeting participants but did not decide which individuals or organizations from the mental health community would have an opportunity to meet with the Vice President's Task Force, but is aware that a wide range of behavioral health professionals representing psychology, social work, counseling, state mental health authorities, county behavioral health authorities, community mental health and substance abuse providers, along with advocates representing children and families who have experienced behavioral health issues, participated. No one testified for the Task Force – these mental health experts and advocates were invited to a meeting with Secretary Sebelius and other Administration officials.

5. **Dr. Fuller Torrey asserted that SAMHSA did not collect data on people living with mental illness who receive social security benefits because agency officials "have no interest in these questions." Is this statement accurate? What barriers exist for SAMHSA to collect information on social security recipients?**

Response: The Social Security Administration is the Federal agency responsible for collecting data on individuals receiving Social Security Disability Insurance. The information that Dr. Torrey may be seeking can be found in the publication, Annual Statistical Report on the Social Security Disability Insurance Program, 2011, at Table 6 (Distribution, by sex and diagnostic group, December 2011).[35] SAMHSA uses this and other data for surveillance, program planning and policy purposes.

6. **Dr. Sally Satel, a witness on the second panel, testified:**

> **When I was on the Advisory Council from 2002 to 2006, we repeatedly were trying to have some input into the decisions regarding the grants that were approved but it was clear that we were pretty much there to rubberstamp those grants. They had already been approved. We asked repeatedly if we could see them prior to approval or if we could review them after approval and then have our assessment be reconsidered, and we were turned away**

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[35] http://www.ssa.gov/policy/docs/statcomps/di_asr/2011/sect01b.pdf.

every time.

Can you explain the role of a member of the Advisory Council? Do participants select the recipients of grants?

Response: The Federal Advisory Committee Act defines an advisory committee as "any committee, board, commission, council, conference, panel, task force, or other similar group" that is "established or utilized" by the President or an agency "in the interest of obtaining advice or recommendations" for the President or one or more agencies or officers of the Federal Government." (5 U.S.C. App. 2 § 3(2))

A member of an Advisory Council serves as a source of independent expertise and advice – not decision-making – on policy and program activities carried out by the committee. A member of an Advisory Council may make recommendations but does not make decisions on technical evaluation reports/summary statements for contract proposals, grants, and cooperative agreements. (Federal Advisory Committee Management Handbook, revised edition January 2003, Part I(E).

The function of advisory committees is advisory only, unless specifically provided by statue or Presidential directive. [41 CFR 102-3.30(e)]

Advisory committees are advisory only and do not select the recipients of grants. All SAMHSA councils and committees perform a policy and program advisory role and the three Center councils have an additional, legally required grant "second-level" review role. (SAMHSA Policy and Guidance Handbook for Advisory Committee Members, Section 2, revised May 2011)

SAMHSA's peer review system, required by law (Section 504 of the Public Health Service Act) and known as a two-level review process, is used to ensure that knowledgeable, objective review of the technical merit and quality of grant and cooperative agreement applications is conducted before funding decisions are made by the officials in SAMHSA. Section 412 of the Health Professional Partnerships Act of 1998 (P.L. 105-392) amended section 504 of the Public Health Service Act by eliminating the requirement for council review of contracts. Thus, councils perform second-level review only for grant and cooperative agreement applications.

The two-level review system involves: (1) peer review by an Initial Review Group; and (2) second-level review by a Center national advisory council. Although all competing grant and cooperative agreement applications are subject to peer review, generally only grant and cooperative agreement applications where the direct costs exceed $150,000 are subject to the second-level council review. The purpose of this second-level council review is primarily to assure the process used by SAMHSA to make decisions on grants using the peer review process is adhered to and is sufficient to assure objectivity, and is not intended to allow advisory council members to select grantees.

The Honorable Paul Tonko

1. **What proportion of SAMHSA's mental health budget in 2013 funded the Consumer and Consumer-Supporter Technical Assistance and the Centers and the Protection and Advocacy for Individuals with Mental Illness program?**

   Response: The National Consumer and Consumer Supporter Technical Assistance Centers consists of five grantees, three of whom are Consumer Technical Assistance Centers and two are Consumer Supporter Technical Assistance Centers. Each is funded at $330,000 annually for a subtotal of $1,650,000. The Consumer and Consumer-Supporter Technical Assistance Centers total funding for FY 2013 is $1,875,102 and represents 0.2 percent of the SAMHSA Mental Health appropriation of $915 million.

   The PAIMI program is 3.75 percent of SAMHSA's FY 2013 mental health budget.

2. **What important services do these two programs provide to people living with serious mental illness?**

   Response: The Technical Assistance Centers assist in the transformation of the mental health system by promoting services for adults with serious mental illnesses. They promote skill development for individuals with mental illnesses (sometimes called consumers) with an emphasis on business and management; strengthening consumer organizations and leadership in communities; collaboration with other consumers, families, advocates, providers, and administrators; coalition building; self-management/self-help approaches to symptom and illness management; evaluation and policy formation; and building opportunities for meaningful paid employment.

   Most of the requests received by the Technical Assistance Centers are for materials; referrals to self-help groups and clinical and non-clinical services; and for trainings. The Technical Assistance Centers have available 169 English-language materials and 23 English-language written training curriculums. The majority of the written training curriculums focus on Assertive Community Treatment teams, recovery, and self-help or organizational skills. The Technical Assistance Centers also have 29 written training curriculums or materials in non-English languages: 17 in Spanish, ten in Japanese, and two in French.

   As mentioned in response to previous questions, the purpose of the PAIMI program is to: (1) ensure that the rights of individuals with mental illness are protected; (2) assist states to establish and operate a protection and advocacy system for individuals with mental illness, which will protect and advocate the rights of such individuals through activities to ensure the enforcement of the Constitution and Federal and state statutes; and (3) investigate incidents of abuse and neglect of individuals with mental illness if the incidents are reported to the system or if there is probable cause to believe that the incidents occurred.

3. **In contrast, what percentages of SAMHSA's mental health funding went directly to States to support mental health treatment services in 2013?**

Response: Over half (54.8 percent) of CMHS funding will go directly to states to support mental health treatment services for people with serious mental illness in FY 2013. Approximately 81 percent of SAMHSA's total CMHS budget for FY 2013 will support adults with and at risk for serious mental illness and/or children with serious emotional disturbance, with grants to states, communities, and other entities. Within the CMHS budget over the last five years, 75-80 percent of all appropriated funding has been used for mental health programs in support of adults with serious mental illness and children with serious emotional disturbance.

4. **What efforts has SAMHSA undertaken to specifically address the issue of mental health stigma and what type of investment do you think is necessary to truly change public opinion on this issue? Are there specific statistics or metrics used by SAMHSA to quantify the impact that mental health stigma has on the rate of untreated mental illness?**

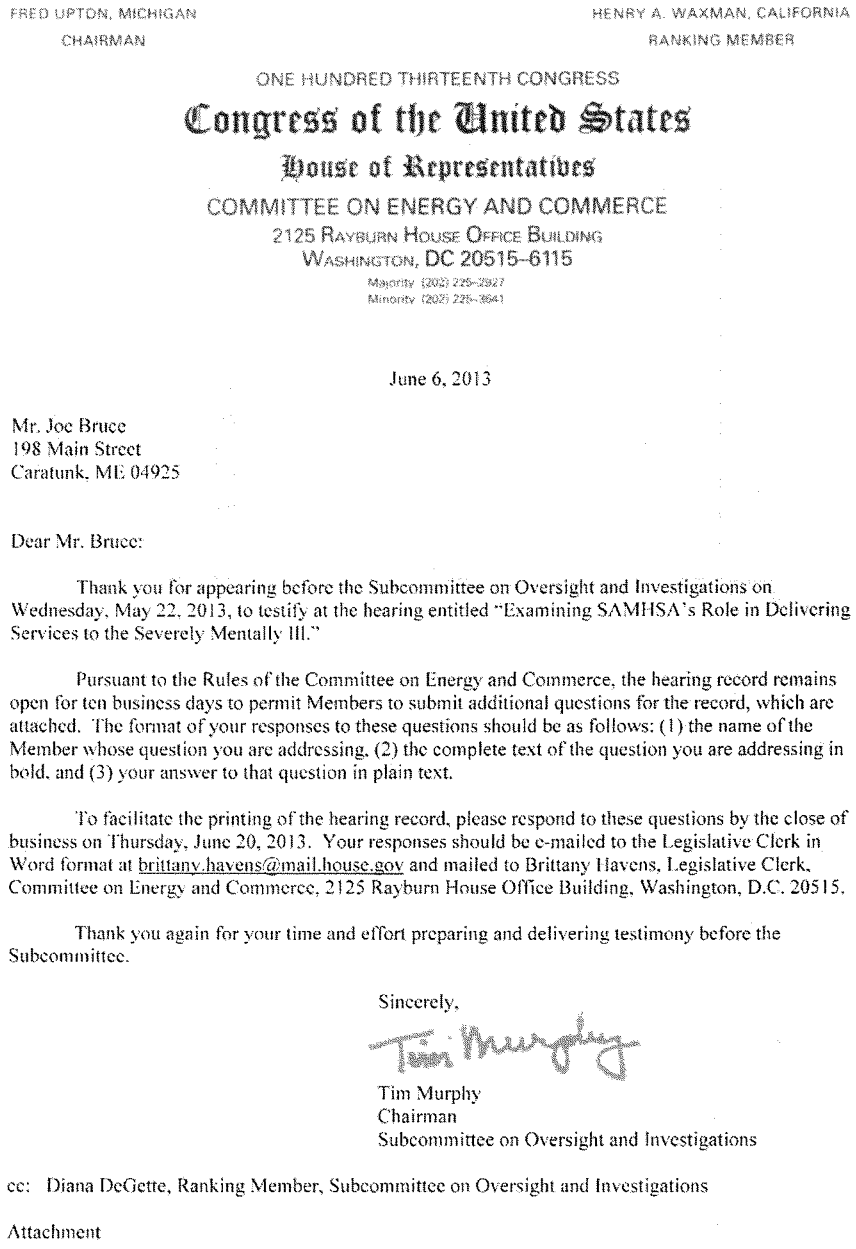
Response: SAMHSA has been working on the issue of negative attitudes associated with mental illnesses since its formation in 1992. SAMHSA has invested in many grants and programs not only to help individuals with mental illnesses find the help they need, but also to change the external prejudice and discrimination associated with mental illnesses and the internal shame and embarrassment that often prevents people from seeking help. SAMHSA has done this through a multitude of programs including the What a Difference a Friend Makes Campaign; the SAMHSA Voice Awards program; the Resource Center to Promote Acceptance, Dignity, and Social Inclusion; National Children's Mental Health Awareness Day; suicide prevention awareness campaigns; and many more. Although these programs have shown to be effective based on evaluations, much more can be done to bring mental illness out of the shadows and be considered by the American public as an acceptable condition for which to seek help. SAMHSA does track survey data in SAMHSA's NSDUH that shows that negative attitudes and prejudice associated with mental illnesses are one of the top reasons individuals avoid seeking treatment and services, and also the fear of disclosing a mental illness to an employer inhibits individuals from seeking treatment. Many national surveys show that the fear of social rejection, prejudice, and discrimination has a chilling effect on help seeking. SAMHSA will continue working to educate people about the importance of behavioral health issues as public health issues; to help reduce negative attitudes, prejudice and misinformation about behavioral health, mental illness, and addictions; and to encourage individuals and families to seek services when they experience mental health and/or substance abuse conditions.

In addition, SAMHSA is participating in the coordination and planning process for the White House's National Conference on Mental Health scheduled for this summer. The purpose of the event will be to discuss how we can all work together to reduce negative attitudes and perceptions about mental illnesses, encourage people experiencing mental health problems to reach out for help, and encourage friends and family members to support their loved ones and connect them with help.

5. **Can you briefly describe the work that SAMHSA does in the area of suicide prevention and discuss what programs like the National Suicide Prevention Hotline are having on reducing the rate of suicide in the United States?**

Response: SAMHSA provides grants to states, tribes and colleges for youth suicide prevention, as authorized by the Garrett Lee Smith Memorial Act. Since the start of the program in 2005, 49 states, 44 tribes, one territory, and 146 college campuses have received funding for their youth suicide prevention efforts. SAMHSA also funds the National Suicide Prevention Lifeline, a network of 161 crisis centers across the United States which answers calls through the toll free number 1-800-273-TALK (8255). The Lifeline currently answers over 80,000 calls per month. SAMHSA-funded evaluations have found that approximately 25 percent of callers to the Lifeline are suicidal at the time they make the call, approximately 20,000 callers per month. The crisis centers 24/7 live trained responders provide crisis intervention , emergency rescue when needed, referral to mental health treatment providers, and other services as well as follow up for suicidal callers. The Lifeline also provides a crisis chat service, and works in collaboration with VA and DOD to route the more than 17,500 callers every month who press "1" to the Veterans Crisis Line.

SAMHSA also funds the Suicide Prevention Resource Center and participates in and helps support the National Action Alliance for Suicide Prevention, a public-private partnership co-chaired by former Senator Gordon Smith and Secretary of the Army John McHugh. Last year, the Action Alliance, working together with the Surgeon General of the United States, released a revised National Strategy for Suicide Prevention. While it is not possible to say what the rate of suicide in the United States would be without these programs, SAMHSA believes that its suicide prevention programs are saving lives. The effort has a goal of reducing the number of deaths by suicide over the next five years.



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June 6, 2013

Mr. Joe Bruce
198 Main Street
Caratunk, ME 04925

Dear Mr. Bruce:

Thank you for appearing before the Subcommittee on Oversight and Investigations on Wednesday, May 22, 2013, to testify at the hearing entitled "Examining SAMHSA's Role in Delivering Services to the Severely Mentally Ill."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions by the close of business on Thursday, June 20, 2013. Your responses should be e-mailed to the Legislative Clerk in Word format at brittany.havens@mail.house.gov and mailed to Brittany Havens, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Tim Murphy

Tim Murphy
Chairman
Subcommittee on Oversight and Investigations

cc: Diana DeGette, Ranking Member, Subcommittee on Oversight and Investigations

Attachment

The Honorable Tim Murphy

1. **You have said that the mental health system, as it is currently constituted, seems designed to handicap families in their efforts to obtain the best treatment and long-term outcomes for their loved ones. In his book, *Out of the Shadows*, E. Fuller Torrey discusses the different ways of ensuring accountability for and measuring performance of mental health services. He gives the example of the Riverside County Department of Mental Health in California that employs a full-time Family Advocate whose job is to solicit information from families about problems in the county mental health treatment system.**
    a. **Could a Family Advocate, or someone like it, have been helpful to you while your son was committed to Riverview? Why or why not?**

I have read Dr. E. Fuller Torrey's comments that any organization funded by the government or by the pharmaceutical industry will find it difficult to criticize either. It is an excellent point that I have to agree with.

Rather than set up separate family advocacy systems, a more immediate and effective remedy is to rewrite HIPAA and PAIMI to remove barriers to family participation in the care of adult patients. In my opinion, three changes should be made to these statutes and regulations.

FIRST, as Peter Mills of Maine has suggested, "Mental health workers should have greater latitude in communicating with caregivers who are providing daily care for someone outside an institution. A limited sacrifice in privacy is the price that a patient should reasonably pay to receive effective care in the least restrictive setting."

I agree and respectfully suggest the following provisions (courtesy of Peter Mills) be added to HIPAA:

> <u>"Caregiver" is a person including a family member who shares responsibility for the day-to-day care or protection of an individual with mental illness.</u>
>
> <u>If an individual with mental illness withholds consent for disclosure because of compromised insight into the nature and extent of the illness, a provider may, without the consent of the individual, disclose to caregivers such protected health information as the provider reasonably believes is necessary either for the health, safety, or welfare of the individual or for the safety of others.</u>
>
> <u>A provider is not liable for failing to make a disclosure in those instances where a threat is not serious and imminent and the disclosure would, in the provider's good faith judgment, interfere with rendering effective care.</u>

SECOND, I urge that Congress enact an amendment to PAIMI to prevent the Patient Advocates from supporting the rejection of treatment by severely mentally ill patients who lack insight into their illness. Peter Mills wrote the following on this subject:

> "Approximately half the people with schizophrenia and 40% of those with bipolar disorder go through periods of 'anosognosia', a deficit of awareness or lack of insight into the nature and extent of the illness.
>
> "In 1986, Congress passed the 'PAIMI' law (for Protection and Advocacy for Individuals with Mental Illness) to create P&A ('Protection and Advocacy') systems in all 50 states to prevent abuse and neglect of people with mental illness. It was modeled on an earlier statute to protect those with developmental disabilities.
>
> "While the statute might have been written to focus on effective care, protection and treatment, it is worded instead to speak of 'rights.' In fact, there is a bill of rights appended to the law.
>
> "The right to treatment has often been interpreted to include the right to reject treatment even if rejection makes the illness worse, causes permanent harm and leads to loss of liberty, incarceration or death.
>
> "Does a patient with anosognosia have the right to a publicly paid advocate whose mission is to block the delivery of effective care? Does the right to reject treatment translate into the right to remain psychotic? What is an advocate to do when a delusional rejection of treatment conflicts with the right to receive treatment?
>
> "PAIMI should define the advocate's role to resolve this common and difficult conflict. It might be done either by prohibiting the advocate from interfering with necessary treatment or, at the very least, by granting the advocate discretion not to interfere even when the patient insists.
>
> "In 42 USC 10802 add the following definition as a new paragraph 6:
>
> "(6) The term 'rights of individuals with mental illness' includes a right to suitable care, protection and treatment. An advocate **may not support** an individual's rejection of necessary treatment if the rejection arises from lack of awareness of a mental illness or lack of insight concerning the nature or extent of a mental illness.
>
> "or
>
> "(6) The term 'rights of individuals with mental illness' includes a right to suitable care, protection and treatment. An advocate **may refuse to support** an individual's rejection of necessary treatment if the rejection arises from lack of awareness of a mental illness or lack of insight concerning the nature and extent of a mental illness."

Personally, having seen the philosophical inclinations of the patient advocates first hand, I prefer the first suggested alternative because it removes discretion from the advocates to support a refusal of treatment.

THIRD, the Patient Advocates should be prohibited from lobbying. As Peter Mills wrote:

> "Protection and Advocacy (P&A) groups have often ignored prohibitions against lobbying. In Maine, they intervened to make it more difficult for a parent to become the guardian of an adult disabled child. Throughout the U.S. they have vigorously opposed passage of outpatient treatment laws even though these laws have been successful in providing "least restrictive alternatives" for treatment.
>
> "Although these laws enhance freedom and opportunity for the mentally ill, advocates on SAMHSA's payroll have often shown up to oppose such measures in state legislatures.
>
> "To the extent that lobbying has been justified by the fact that P&A groups receive some of their funding from non-federal sources, the law should perhaps be changed to prohibit lobbying by a P&A group that receives any funding under PAIMI.
>
> "Law Professor Amanda Peters concluded:
>
> > 'The only effective way of preventing lobbying is to do as Congress has done with the Legal Services Corporation: consider passing additional laws that prevent patient advocates from using *any* funds to lobby, set up an agency to closely monitor their spending and lobbying efforts, and come up with a plan to unfund or otherwise punish advocates who nevertheless engage in such activity.' 89 Oregon Law Rev. 133, 156."

* * *

In conclusion, I believe that these three changes would not only have helped the Bruce family, but would help families with severely mentally ill loved ones across the country and be in the best interests of the severely mentally ill themselves. Like the mothers of severely mentally ill individuals I have met from across the country, Amy Bruce was the greatest advocate our son could ever have had. Opening the iron curtain of HIPAA to allow family members to be involved in their adult loved ones' treatment would simultaneously increase the efficacy of that treatment and provide costless oversight – which is currently lacking – of the activities of the individual patient advocates and of the entire system. In the case of the Bruce family it would likely have saved Amy's life.

Thank you for giving me this opportunity to give you my thoughts on this important subject.

Sincerely,
Robert (Joe) Bruce
Caratunk, Maine

FRED UPTON, MICHIGAN
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
RANKING MEMBER

ONE HUNDRED THIRTEENTH CONGRESS
Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
2125 Rayburn House Office Building
Washington, DC 20515–6115
Majority (202) 225-2927
Minority (202) 225-3641

June 6, 2013

Dr. E. Fuller Torrey
Founder
Treatment Advocacy Center
6204 Ridge Drive
Bethesda, MD 20816

Dear Dr. Torrey:

Thank you for appearing before the Subcommittee on Oversight and Investigations on Wednesday, May 22, 2013, to testify at the hearing entitled "Examining SAMHSA's Role in Delivering Services to the Severely Mentally Ill."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions by the close of business on Thursday, June 20, 2013. Your responses should be e-mailed to the Legislative Clerk in Word format at brittany.havens@mail.house.gov and mailed to Brittany Havens, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Tim Murphy

Tim Murphy
Chairman
Subcommittee on Oversight and Investigations

cc: Diana DeGette, Ranking Member, Subcommittee on Oversight and Investigations

Attachment

<u>**The Honorable Tim Murphy**</u>

1. **Patients and health providers have their advocates. What about the families of the mentally ill? What about people like Joe Bruce?**
   a. **In your book, *Out of the Shadows*, you discuss the different ways of ensuring accountability for and measuring the performance of mental health services. You give the example of the Riverside County Department of Mental Health in California that employs a full-time Family Advocate whose job is to solicit information from families about problems in the county mental health treatment system. As far as you know, has the practice expanded since your book came out? Would it help? Why or why not?**

      I described the Riverside County family advocate program as it existed in the mid-1990s. At that time, the county had an excellent Director of Mental Health who was very interested in improving the county's services for individuals with serious mental illnesses. The family advocate program has continued in Riverside County and has spread to approximately six other counties in California. However, its usefulness depends largely on the interests of the county Director of Mental Health. In Riverside County, for example, the person who replaced the man who started the program has had less interest in using the information.

      Do such programs help to improve services? They certainly can do so by providing ongoing input from patients and families to county officials regarding what is and is not working and weaknesses in their programs. This assumes, of course, that the county officials want such information, which is currently not true except in unusual instances. County officials will want such information only if they are being evaluated on how well they are doing their job and are being held responsible for patient outcomes. Presently, because of the thought-disordered way we are funding mental illness services, county officials are largely judged on a single criteria, and that is how successful they are in shifting the cost of services from the county and state to federal sources, especially Medicaid and Medicare. If the primary funding for mental illness services was shifted from the federal government back to the states, as existed prior to 1963 when the federal Community Mental Health Centers Act was passed, and the states were held fully responsible for mental illness services, then the use of family advocates would become widespread.

   b. **Is SAMHSA presently funding programs that promote the spread of Family Advocates? Should they be?**

      SAMHSA has funded, and currently is funding as far as I know, Mental Health America (MHA) and NAMI, the two largest associations of family advocates. I do not believe that SAMHSA or any other government agency, federal or state, should be funding such advocacy groups, since it renders them completely ineffective as advocates. For family or patient mental illness advocacy groups to be effective, they must be able to publicly criticize government agencies which are failing to do an adequate job on services and/or research. Without this ability such advocacy groups are effectively emasculated, and operate merely with the appearance of being an advocacy group but without any ability to do so.

Government agencies, of course, know this and that is why they fund the advocacy groups. Thus when SAMHSA was recently being criticized, Mental Health America publicly sprang to SAMHSA's defense and suddenly decided to give SAMHSA Administrator Pamela Hyde a public award. Similarly, the majority of state NAMI offices now receive the majority of their funding from the state departments of mental health (e.g., in New York State it is 92 percent), and are thus unable to criticize the departments. As state mental illness services have deteriorated progressively over the past two decades, it is remarkable how quiet most state and national NAMI and MHA groups have been. For advocacy groups to be effective, they must be completely financially independent from the government agencies which are the objects of their advocacy. This is why the Treatment Advocacy Center, which I founded, has never accepted any funds from government agencies or from pharmaceutical companies.

The Honorable Paul Tonko

1. **Dr. Torrey, you have been an outspoken critic of SAMHSA for quite some time and have repeatedly called for its abolishment. You acknowledge, however, that some programs at SAMHSA have merit and value. In your opinion, what are the "good programs" at SAMHSA that you would like to keep and potentially expand?**

I have indeed called for the abolishment of SAMHSA for more than a decade but have never said that SAMHSA did not have some programs of merit and value. Such programs would be much more valuable, however, if transferred to other agencies, such as was proposed by Senator Tom Coburn in his analysis of SAMHSA in his 2011 report, "Back in Black." Examples of SAMHSA programs which I believe have some merit include:

- The data collection branch: This branch has competent staff but is badly underutilized because they are not asked to collect the most relevant data. For example, they collect data on the decreasing number of public psychiatric beds available but do not collect data on the logical corollary: where to such patients go if the beds are no longer available? The answer is to jails, prisons, and the streets.

- Integrated "wraparound" services for adolescents with mental illness and substance abuse disorders: Some of these programs are excellent. However, SAMHSA should fund such programs as demonstration projects, not permanent funding. They should carefully evaluate what works and what does not work, and demonstrate how these programs ultimately save money.

- Programs for homeless individuals with serious mental illness: Some of these programs have been very useful. Like the "wraparound" services, however, they should be funded as demonstration programs with careful cost-benefit evaluations, not as permanent federal funding as is now the case. Another shortcoming of this program is SAMHSA's requirement that the mentally ill homeless persons being served by the program must agree to the services. This assumes that the mentally ill individual is aware of their own illness and need for treatment. I personally volunteered for 16 years in free clinics for homeless individuals in Washington, D.C. and can testify that no more than one-quarter of homeless mentally ill individuals are aware of their illness and need for treatment. The other three-quarters have a lack of awareness of their illness caused by damage to the brain by their mental illness, a condition we call anosognosia. Thus this SAMHSA program, which is one of the agency's best programs, is ineffective for three-quarters of its target population.

- Mental Health Block Grant: In theory, this should be one of SAMHSA's best programs and in fact it does some good, not because of SAMHSA but despite SAMHSA. The purpose of these Block Grants, as described in federal statutes (section 300, formula grants to states, under Title 42, The Public Health and Welfare) is to improve "community mental health services to individuals who are either adults with a serious mental illness or children with a serious emotional disturbance." The target population for these Block Grants is thus clearly prescribed by law. However, SAMHSA has its own priorities for the mental health Block Grants, as detailed on its website: "SAMHSA strongly recommends that Block Grant funds be directed...to fund...prevention activities and services for individuals not identified as needing treatment." Since we have no knowledge of how to prevent serious mental illnesses, to order the funds for this program to be used for prevention and for individuals "not identified as needing treatment" is absurd and probably illegal.

- Specifically regarding your Congressional district (21st New York) I would like to point out one other important shortcoming of SAMHSA. In 1977, a study was done in Albany County in which the number of homicides committed by mentally ill individuals for the period before wholesale discharges from psychiatric hospitals (1963-69) was compared with the number of homicides after discharges were underway (1970-75). Although the number of homicides by non-mentally ill individuals did not change between the two periods, the number of homicides by seriously mentally ill individuals increased from one (an eighty-two-year-old man with dementia) to eight, all of whom were diagnosed with schizophrenia. These eight individuals were responsible for 29 percent of all homicides in the county during the six-year period. The authors of the study recommended that additional studies be done and concluded that "closer follow-ups of psychotic patients, especially schizophrenics, could do a lot to improve the welfare of the patient and the community."[i] Such additional studies, which should have been done by SAMHSA, were never done and "closer follow-ups of psychotic patients" never took place. That is why your Congressional district and every other Congressional district, has continued to see a *minimum* of 10 percent of all homicides committed by seriously mentally ill individuals who are not being treated. This issue has been completely ignored by SAMHSA.

Please let me know if you have additional questions.

E. Fuller Torrey MD
Founder, Treatment Advocacy Center

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[i] F. Grunberg, B.I. Klinger, and B. Grumet, "Homicide and deinstitutionalization of the mentally ill," *American Journal of Psychiatry* 134 (1977): 685-87; F. Grunberg, B. I. Klinger, and B. R. Grumet, "Homicide and community-based psychiatry," *Journal of Nervous and Mental Disease* 166 (1978): 868-74.

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June 6, 2013

Dr. Sally Satel
Resident Scholar
American Enterprise Institute
1150 17th Street, N.W.
Washington, D.C. 20036

Dear Dr. Satel:

Thank you for appearing before the Subcommittee on Oversight and Investigations on Wednesday, May 22, 2013, to testify at the hearing entitled "Examining SAMHSA's Role in Delivering Services to the Severely Mentally Ill."

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Sincerely,

Tim Murphy

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Chairman
Subcommittee on Oversight and Investigations

cc: Diana DeGette, Ranking Member, Subcommittee on Oversight and Investigations

Attachment

American Enterprise Institute
for Public Policy Research

The Honorable Tim Murphy
Attn. Brittany Havens
Legislative Clerk, Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, D.C. 20515

June 10, 2013

Dear Congressman Murphy

Thank you for your dedication to this issue. You ask:

Do you see any benefit in de-monopolizing the Protection & Advocacy system altogether? That is, allowing states to select attorneys for individual representation on a competitive basis, rather than contracting these representations out to a designated organization in each state, like the Disability Rights Center of Maine in Mr. Bruce's Case?

As a rule, SAMHSA should not enter into contracts with or endorse any clinical or legal entity that is averse to or dismissive of the practices mainstream psychiatry. I am referring here, specifically, to the appropriate use of psychiatric medication, involuntary hospitalization or mandated outpatient care.

I see potential benefit in allowing states to select attorneys to represent severely mentally ill patients in commitment proceedings, but there must be a mechanism of some sort for HHS to override a state's choice if the attorney chosen rejects the practices of mainstream psychiatry. Given the popularity of the "recovery model" at the level of state mental health departments (granted, far more pronounced in some states than others), simply allowing states latitude is not a guarantee of reasonable representation.

Thank you for your attention

Sally Satel MD

FRED UPTON, MICHIGAN
CHAIRMAN

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June 6, 2013

Dr. Joseph Parks, III
Chief Clinical Officer
Missouri Department of Mental Health
1706 East Elm Street, P.O. Box 687
Jefferson City, MO 65102-0687

Dear Dr. Parks:

Thank you for appearing before the Subcommittee on Oversight and Investigations on Wednesday, May 22, 2013, to testify at the hearing entitled "Examining SAMHSA's Role in Delivering Services to the Severely Mentally Ill."

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cc: Diana DeGette, Ranking Member, Subcommittee on Oversight and Investigations

Attachment

June 24, 2013

Brittany Havens
Legislative Clerk
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

Dear Ms. Havens:

As a follow up to the questions from Rep. Waxman in regard to the Subcommittee on Oversight and Investigations Hearing on "Examining SAMHSA's Role in Delivering Services to the Severely Mentally Ill," please find attached my responses to each question for Rep. Waxman's consideration.

I appreciate the opportunity very much to respond to these critically important questions, as it helps to further expand on my written and oral testimony provided at the May 22 Oversight Sub-committee hearing on SAMHSA's initiatives.

I would be pleased to respond to any follow up questions based on the enclosed additional remarks, or additional questions that may arise during your deliberations.

Thank you again for inviting me to testify at the May 22 Oversight Hearing, and the opportunity to address further queries through this written submission.

Sincerely,

Joseph Parks, M.D.
1840 E Highway 163
Columbia, MO 65201

Responses to Rep. Waxman's Follow-Up Questions

Can you explain how SAMHSA's Co-Occurring State Incentive Grants (COSIG) helped your state improve the ability of community mental health centers and substance abuse treatment agencies to promptly and effectively serve people who have both mental illness and substance abuse conditions simultaneously? Is this program still in effect? What steps can Congress take?

The COSIG grants improved the ability of both community mental health centers and substance abuse provider agencies, to serve persons that had both mental illness and substance abuse concurrently. Prior to these grants it would be common for a person who had both serious mental illness and addiction to be told by the community mental health center that they could not be treated for their serious mental illness until their addiction was treated and substance abuse treatment agencies would not treat them until their serious mental illness was stable. COSIG provided training and technical assistance so that both Community Mental Health Centers and Substance Abuse Treatment Agencies became competent and comfortable working with patients who have co-occurring Mental illness and addiction.

Since the COSIG grants have been in place, there is truly "a no wrong door" approach by community mental health centers and substance abuse treatment provider agencies in both welcoming the person needing treatment and engaging them immediately. This is a particularly important improvement with respect to reducing violence by persons with mental illness. The presence or absence of a substance use disorder is the major predictive factor of whether or not a person with mental illness will be more violent than a person without mental illness. In addition, integrated treatment of substance abuse and mental illness is more effective than treating only one condition and more efficient than treating the conditions simultaneously through using two different clinics or programs.

The COSIG grant program has ended, but further progress is needed. Congress should provide funding to SAMHSA for a new round of COSIG grants.

How do you anticipate the Affordable Care Act will impact services for people living with mental illness in your state?

Much of the impact of the ACA in Missouri hinges on whether or not Missouri expands Medicaid. If Missouri chooses to expand Medicaid to 138% of poverty, THE Department of Mental Health (DMH) prevalence estimates and utilization trends tell us that nearly 50,000 of the 300,000 newly eligible Missourians will obtain treatment annually through DMH: 65% for substance abuse – 35% for serious mental illness. Most will not be new to DMH. About 34,000 of those individuals – now indigent – who would qualify under Medicaid expansion would seek DMH services annually anyway, whether or not the state expands Medicaid coverage. Services for these indigent clients are now covered fully by state or block grant funds, or through charity care delivered by DMH's contracted community behavioral health providers. Without insurance or Medicaid coverage, indigent care services are limited and crisis focused. Today, the average annual cost for individuals receiving DMH behavioral health services is about $2,800. The cost of adding 50,000 consumers is about $140 million. The 10% state match ultimately required by Medicaid expansion is $14 million and can be fully funded from cost offsets in DMH's core budget as indigent our consumers become Medicaid eligible. Missouri's mental health system is now largely focused on Medicaid eligible individuals to maximize limited funding. Most of its community program dollars serve people who are categorically Medicaid eligible by disability determination, and for their ancillary services that Medicaid doesn't cover. Unfortunately, only a small percentage of Missourians with substance use disorders now qualify for Medicaid. And young adults, in early stages of serious mental illness, only become Medicaid-eligible after being determined disabled, usually through a lengthy federal eligibility process that is extremely difficult to navigate for people with mental illnesses.

DMH's behavioral health system turns away 100,000 Missourians annually. What this means, in real-world terms, is that most young adults, beginning to experience mental illnesses, like Schizophrenia or Bipolar Disorder, will go for years with inadequate treatment, or none at all. As their illnesses progress, they move from crisis to crisis, appearing frequently in hospital ERs. Some are involuntarily committed by courts to short-term, episodic inpatient treatment. Some commit law violations, mostly minor nuisance violations, but that ultimately ensnares them in the criminal justice system.

Many, if not most of these individuals, initially fight outpatient mental health treatment and fail to take their medications, either because they don't think they need treatment, or because of the detrimental side effects of the powerful psychotropic medications they are prescribed, or because they feel stigmatized by the their mental illness. And their desperate families don't know where to turn for help. The sad outcome of all this is that thousands of confused, vulnerable young people decompensate and become long-term victims of poverty, poor health care, crime and abuse long before they ever enter DMH's services continuum. When they do enter our system, they are older and their conditions have deteriorated to the point that they require more expensive services. Most develop serious, chronic medical conditions, like hypertension, diabetes, heart disease, and COPD. On average, they will die between the ages of 50-60 years old. Eight of ten will die from their chronic medical condition.

Although people with mental illness are far more likely to be victims of crime than perpetrators, a small number strike out at society. We hear about them in local, state and national news, and we mourn their actions. The ACA Medicaid expansion can change this. New services can be tailored to young people in earlier stages of mental illness without the need for stigmatizing disability labels. This would be of immeasurable value to vulnerable consumers and their exhausted families, and would represent a long overdue "sea change" toward early intervention for mental health. There is also a major Missouri mental health system downside to not accepting Medicaid expansion.

Under ACA, Missouri's community hospitals, some of whom now do all of the acute psychiatric inpatient care in our state, will lose about $250 million in federal disproportionate share (DSH) funding for the indigent patients they serve because it is assumed that hospitals will receive Medicaid reimbursement for these patients once the Medicaid expansion occurs. It is critical to understand that the percentage of indigent care patients is much higher on psychiatric units than on general medical units in these hospitals. For example, Cox Medical Center in Springfield has an overall patient mix of only 7% indigent patients, but 22% of its psychiatric patients are indigent. When hospitals incur the DSH cuts, they will first be forced to close psychiatric units serving indigent adult patients under age 65.

Currently, there are only 1,170 acute psychiatric beds for adult, non-geriatric patients left in Missouri. We have lost 1,400 psychiatric beds in this state since 1990. We now have one acute psychiatric bed for every 2,800 Missourians. In comparison, we have one medical hospital bed for every 300 Missourians. This has placed an incredible strain on the system, and it has affected county and city law enforcement units, who must transport these patients longer distances and remain with them as they are processed by community hospital emergency rooms and ultimately transferred to a psychiatric bed, if available. If not, the individual often winds up in a county jail. Not expanding Medicaid guarantees the further elimination of adult psychiatric beds in Missouri and will ultimately put pressure on the state to reopen acute psychiatric beds.

We closed our acute care beds in Kansas City, St. Louis, Columbia and Farmington in FY 2010-2011 due to budget cuts. A state-operated acute inpatient psychiatric bed will cost roughly $900 per day, or about $33 million per year for each 100 beds, not counting capital costs. The state will receive no Medicaid reimbursement because the federal government prohibits it, and will receive dramatically reduced DSH funding. County and city jails, already stressed with untreated mentally ill individuals, will initially feel the brunt of the loss of more beds. Corrections will also feel it. Now, over 16% of all inmates incarcerated in DOC are treated for a serious mental illness. That number and percentage will grow. For mental health services in Missouri, the decision to expand or not to expand Medicaid will create a sea change for Missouri, either way it goes. If it is not accepted, I believe that the resulting sea change downward is even more threatening than the sea change up if expansion occurs.

Aside from Medicaid expansion the ACA will provide life changing and life saving benefits to people in Missouri with mental illness. The combination of requiring community rating, parity with medical benefits, and prohibiting the exclusion of pre-existing conditions from coverage will give people with mental illness access to decent affordable health insurance. The numerous programs and incentives to integrate mental health care and medical care in the ACA, particularly the Medicaid Health Homes for Persons with Chronic Conditions (Section 2703) are bringing transformative improvements to care that are saving both lives and money.

In 2008, the Mental Health Parity Addiction and Equity Act was enacted. Many of the Committee members co-sponsored and voted for this legislation. How does the mental health parity law impact people living with mental illness in your state?

The Mental Health Parity Addiction Equity Act has significantly improved access to mental health treatment particularly in the area of quantitative limits. Persons with mental illness are no longer faced with arbitrary limitations on the number of treatment visits they can have with their mental health clinician and no longer have to pay higher co-pays and deductibles that are paid for the treatment of medical illnesses. There has not been as much progress in achieving the parity goals of the act in the area of qualitative limits. For instance many plans that allow for a period of several weeks of more intensive rehabilitation services following a stroke or a heart attack are still not providing the same period of intensive rehabilitation services following a hospital admission for a psychotic episode or suicide attempt. Congress should make funding available to assist patients work through the administratively complicated appeals process laid out in the legislation. Persons with mental illness commonly have impairments of concentration, memory, attention, and difficulties with organization and persistence, all of which are required to successfully avail themselves of their appeal rights. Providing funding to assist mentally ill persons with the appeal process and including such assistance as one of the functions of existing funded advocacy and rights programs is necessary to achieve full implementation of the Mental Health Parity Addiction and Equity Act.

Dr. Parks, what next steps can Congress take to provide the best treatment for those living with mental health issues?

My Recommendations are:

1) **Increase the Resources Available through SAMHSA MENTAL HEALTH Block Grant (MHBG) and Discretionary Grants.**

SAMHSA resources have not kept pace with either the general rate of inflation in the cost of care or with the markedly increased demand for mental health services that has occurred in the last 10 years. THE MHBG and discretionary provide important tools to states and communities for improving the treatment of serious mental illness and providing the early interventions that will be the most effective means of reducing violence involving persons with serious mental illness.

2) **Develop a National Approach for Increasing the Psychiatric Workforce**

The demand for psychiatric services is far outstripping the ability of the available workforce to supply them this is increasingly severely restricting access to essential treatment services for persons with serious mental illness. According to a University of North Carolina (UNC) 2008 study commissioned by Health Resources and Services Administration (HRSA) the United States have a significant shortage of mental health professionals, especially "prescribers". The current supply of psychiatrists is at least 30,000 short of what is needed.

The projected demand for all physicians continues to rise outstripping the projected increase in physicians. For psychiatry, the anticipated demand has risen dramatically. The number of people seeking psychiatric services has increased because of the growing and aging population, mental health parity and anti-stigma efforts.

The number of psychiatric problems has increased because of the economic downturn and the psychological toll of two wars. Other factors increasing the demand for psychiatrists are direct marketing of psychiatric medications to the public and an increase in the number of black box warnings causing primary care clinicians to be reluctant to prescribe psychotropic medications. This is occurring at the same time that the projected supply of psychiatrists is flat.

Psychiatrists are not increasing in number because retirements are outnumbering those entering the workforce through training. Currently 55% of psychiatrists are older than age 55. In a recent projection using a similar methodology to the UNC study, the deficit has increased to 45,000. Patients often have to wait months to see a psychiatrist because clinics cannot find enough psychiatrists to hire to provide service. Hospitals have closed their psychiatric units due to difficulties recruiting psychiatrists to staff them. Current national shortages in mental health professionals specifically psychiatrists will continue to exacerbate. All projections estimate the gap between unmet need and supply will widen substantially over the next 20 years.

3) **Specific Discretionary Grant Recommendations**

a. **Grants Funding Mental Health First Aid (MHFA)** – Early identification and treatment can prevent a mental illness from developing into a disability or leading to suicide or violence against others. Mental Health First Aid is a groundbreaking public education program that helps the public identify, understand, and respond to signs of mental illnesses and substance use disorders.

The idea behind MHFA is no different than that of traditional first aid: to create an environment where people know how to help someone in emergency situations. But instead of learning how to give CPR or how to treat a broken bone, the program teaches people how to recognize the signs and symptoms of mental health problems and how to provide initial aid before guiding a person toward appropriate professional help.

Mental Health First Aid is offered in the form of an interactive 8-hour course that is presented by instructors who have been certified through intensive 5-day training. The course presents an overview of mental illness and substance use disorders in the U.S. and introduces participants to risk factors and warning signs of mental health problems, builds understanding of their impact, and overviews common treatments. Those who take the course to certify as Mental Health First Aiders learn an action plan encompassing the skills, resources and knowledge to help an individual in crisis connect with appropriate professional, peer, social, and self-help care. Since its introduction in the U.S. four years ago, more than 50,000 people have been trained in 47 states and the District of Columbia. Mental Health First Aid can create community environments more alert, and prepared, to intervene in the mental distress that leads to suicide and violence against others.

b. Grants to Implement and Improve the Integrated Treatment of Substance Abuse Disorders and Mental Disorders in Persons with SMI

The presence of substance abuse is the strongest protector that persons with SMI will commit violence. We can do better addressing substance abuse disorders in people with SMI.

c. Grants Supporting Effective Early Treatment of Psychotic Illness. –

Our nation's approach to helping people with psychotic illnesses like schizophrenia is shameful. Usually, young people slip into psychotic illnesses for several years while these individuals—or their families—get no help. When they have a "first psychotic break," they usually are briefly hospitalized. Almost always, medications take the worst of the symptoms away—within days or weeks. So then they are discharged with a referral to care and maybe a recommendation of a support group. This is woefully deficient.

Having symptoms reduced is not a cure. When people feel better, and especially since the drugs have significant side effects, they often stop taking them. Relapse is likely. Usually the second break is worse. And then the revolving door begins. Often after decades people figure out how to manage their illness, but by then they are often on permanent disability status, unemployed, and in terrible health.

Some have suggested that the solution to this problem is in going backward—not forward—to days when stays in mental hospitals were measured in months and years. This is not the approach I would advocate. There is no research to suggest it is effective. It is terribly expensive. Hospitals cannot be run (as the old asylums were) on unpaid patient labor. And a civilized society cannot detain people on a vague hope they will get better.

So we should not turn the clock back on mental health care. But we do need a modern approach to care for people with psychotic disorders, one that replaces both the asylum and the revolving door with continuous team treatment like that we provide for people with chronic medical problems. Teams delivering First Episode Psychosis (FEP) care have figured out how to do this work. It is person-centered, family driven, collaborative and recovery oriented. Staying in school or work is encouraged—though adaptations may be needed. It is time to implement this approach, as both Australia and Great Britain have done. We need not lag behind other nations in this area. Our country needs to make modest investments now to develop FEP teams so that families anywhere in the state struggling with a young adult who is slipping away from sanity can get good care reasonably close to home. The Committee's attention to this issue could have an enormous positive effect.

4) Make HIPAA Work as it was Originally Intended

Although HIPAA explicitly allows health care providers and providers of healthcare related services to share protected health information absent patient consent for the purposes of treatment, which includes care coordination, many health care providers continue to insist that they can only share protected health information with patient consent. Adding additional groups with whom health care providers are allowed to share information, such as family members who are directly supporting the persons coordination of care, is unlikely to be successful when health care providers routinely interpret HIPAA as prohibiting sharing protected health information absent patient consent even between other health care providers when in fact that is what HIPAA explicitly allows. These health care providers are taking an inappropriately restrictive interpretation of HIPAA in an attempt to reduce their personal and organizational liability as opposed to taking an interpretation that maximizes the patient's best interests in receiving coordinated care. In short their primary goal is not what is best for the patient but rather how best to limit their own liability risks. This is both clinically dangerous for patients because it results in information not being shared that would improve care decisions and economically wasteful for the health care system in that it results in unnecessary repetition of assessments, tests, and hospitalizations.

There is a need for a national initiative to retrain health care providers to error on the side of sharing protected health information when it would benefit the individual receiving treatment. There is a need for a national strategy to make the perceived liability risk of not sharing information when it could have been shared, and the lack of sharing information, results in patient harm as great as or greater than the perceived risk of sharing information absent patient consent.

5) Increase Federal Support for Mental Health Courts

I have been involved in providing mandatory treatment through different modalities including inpatient and outpatient civil commitment, guardianship, not guilty by reason of insanity processes, probate court order and both mental health and drug courts in Ohio, Illinois, and Missouri. All three states have outpatient commitment laws and in all three states they are difficult to implement and only used rarely. The major barrier has been the unwillingness of police and sheriff departments to commit resources to enforcing violations of commitment orders. Local law enforcement almost uniformly state that they do not have the resources in terms of officers available to assist with mental health treatment in this manner and that crimes the have been committed or are being committed are a higher priority for community safety.

Please ensure departments are usually effective in persuading the local judges to make orders for outpatient commitment rarely if at all. There has been much more success nationally in implementing mental health courts were a person is required to accept treatment for their mental illness as a condition of probation or parole. This is more acceptable local law enforcement because it helps keep mentally ill people out of their jails, more acceptable to the courts because it provides them with an additional option or disposition of the case, and more acceptable to mentally ill person who is usually more ready to admit they have committed a crime then they are so sick that they must have treatment is a civil probate requirement because they might do something dangerous in the future. There is been much more federal support available for implementing drug courts and there has been for mental health courts.

The best current strategy for increasing the in availability of mandatory treatment for persons with serious mental illness would be to increase federal support for mental health courts which are easier to implement and more acceptable to both local law enforcement and the persons being mandated in to treatment.

6) Treat the Appalling Rate of Premature Death Among Persons with Serious Mental Illness in the Public Mental Health System like the National Epidemic It Is

It has been over 10 years now since research showed that persons in the public mental health system most of whom have serious mental illness are dying on average 25 years younger than the general population. This is a higher death rate than experienced currently by persons with HIV and on a par with sub-Saharan Africa. Over 80% of the premature deaths and years of life lost are due to chronic medical conditions, not suicide or accidents. There is no federal agency that is routinely and systematically tracking this epidemic let alone addressing it.

a. Persons with serious mental illness should be federally designated as a distinct at risk health disparities population
b. The CDC and SAMHSA should develop, implement, and fund national annual surveillance of the mortality rates and causes of death in persons with serious mental illness.
c. HHS and SAMHSA should develop, implement, and fund a national strategy specifically for reducing premature death among persons with serious mental illness by promoting the integration of behavioral health care and general medical care.

What is the value of the HIPAA law? Why is patient privacy important with regard to treating those with mental illnesses?

HIPAA as written in statute provides both reasonable protections to patient privacy and reasonable access to health information when it is necessary for individual treatment and efficient healthcare delivery.

Can you explain how HIPAA is impacting the coordination of care among mental health care providers?

Persons with serious mental illness are much more likely than the general population to have multiple chronic medical problems in addition to their mental illness. It is common for persons with serious mental illness to see 20 or more different health care providers in a single year and take 20 or more different medications prescribed by multiple physicians. HIPAA as written in statute allows health care providers to communicate to coordinate care even without patient consent. This is essential since it is not possible to anticipate what providers an individual will see in the future, and it is not reasonable to expect anyone and especially persons with mental illness to remember all every provider they have seen in all the details of their care.

Patients cannot provide consent unless they remember all the providers that they have seen. In my career, I have seen many more patients harmed when information was not appropriately shared, compared to patients harmed when information was inappropriately released. When health care organizations implement HIPAA as written there is administratively efficient sharing of critical individual clinical information that is life saving and health enhancing.

HIPAA allows disclosures to share and discuss medical information with family, friends, and individuals involved with a patient's care in appropriate circumstances. Have you encountered health care providers taking an inappropriately restrictive interpretation of HIPAA privacy rules?

Unfortunately it is quite common for health care organizations to impose many more restrictions on sharing individual health information for treatment and coordination of care is required under HIPAA. I commonly encounter health care organization privacy officers, risk managers, and general counsels who have not actually read HIPAA or advise their organizations to be more restrictive "just to be safe". They appear to believe that this will somehow reduce their organization's legal liability and believe that that is more important to reduce their organizations potential liability from sharing information than it is to prevent harm from occurring due to information not being appropriately shared.

There is another inappropriate and burdensome restriction to sharing patient information for coordination of care and treatment in the case of persons receiving treatment for alcoholism and drug addiction. A separate federal statute and regulation commonly referred to as 42CFR puts much greater restriction on any information related to the treatment of alcoholism and substance abuse disorders that occur under HIPAA. This impacts persons with mental illness since many of them also suffer from alcoholism and addictions. Since co-occurring substance abuse and alcoholism is the major factor associated with violence by persons with mental illness 42CFR actually prevents clinicians treating persons with mental illness from accurately assessing risk of violence and intervening to reduce the risk of violence.

Under 42CFR, information cannot be shared without explicit and specific patient consent and that consent must be time-limited with an automatic expiration date. Persons with alcoholism and addictions commonly have multiple chronic medical problems and are frequently prescribed more medications than persons without these disorders. Mental health clinicians need the restricted information to accurately diagnose, assess risk of violence and treat persons with co-occurring substance abuse and alcoholism. Persons with alcoholism and addiction need the support and encouragement of all their healthcare providers in achieving and maintaining sobriety not just their substance abuse treatment programs. 42CFR actually discriminates against persons with alcoholism and addictions because they cannot get the same level of coordination of care for all their health care conditions that are available to patients with other conditions. Treating alcoholism and addictions differently from other conditions under the privacy laws promotes and keeps alive the stigma that these conditions are somehow intrinsically different and less worthy of good clinical care than other healthcare conditions. Separate is never equal. Congress should repeal 42CFR.

Do you have any suggestions on how we can address the problems with the mistaken way HIPAA is often applied?

Congress should mandate and fund a substantial HIPAA re-education initiative targeted at health organization's privacy officers, risk managers, general counsels, and CEOs. In particular HHS should assert and require that health organization's privacy officers, risk managers, general counsels, and CEOs acknowledge that they understand that:

HIPAA allows sharing healthcare information between providers directly involved in treatment absent patient consent.

a) HIPAA allows sharing health care information between providers directly involved in treatment even when the patient requests information not be shared.
b) Neglect has occurred if a patient comes to harm due to health care information not being shared when it could have been and should have been shared in order to coordinate care and provide the best possible treatment outcomes.
c) The failure to appropriately share health care information for coordination of care and to provide the best possible treatment outcomes is substandard care and outside of the acceptable community standard of treatment.
d) A simple and clear statement that the appropriate sharing of health care information for coordination of care and to provide the best possible treatment outcomes – is a requirement for adequate care on a par with having infection control procedures – will go a very long way to ending the inappropriate and self-serving restrictions on the flow of information necessary for good clinical care.