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# ASSESSING THE STATE OF AMERICA'S MENTAL HEALTH SYSTEM

## HEARING

BEFORE THE

## COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

## UNITED STATES SENATE

ONE HUNDRED THIRTEENTH CONGRESS

FIRST SESSION

ON

EXAMINING THE STATE OF AMERICA'S MENTAL HEALTH SYSTEM

JANUARY 24, 2013

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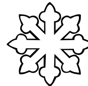

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# ASSESSING THE STATE OF AMERICA'S MENTAL HEALTH SYSTEM

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**THURSDAY, JANUARY 24, 2013**

U.S. SENATE,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
*Washington, DC.*

The committee met, pursuant to notice, at 10:02 a.m., in Room SD–430, Dirksen Senate Office Building, Hon. Tom Harkin, chairman of the committee, presiding.

Present: Senators Harkin, Mikulski, Murray, Sanders, Franken, Bennet, Whitehouse, Baldwin, Murphy, Warren, Alexander, Enzi, and Murkowski.

OPENING STATEMENT OF SENATOR HARKIN

The CHAIRMAN. The Senate Committee on Health, Education, Labor, and Pensions will please come to order.

My first order of business this morning is to extend a warm welcome to our committee's new members, in alphabetical order, Senator Tammy Baldwin, Senator Chris Murphy, Senator Tim Scott, and Senator Elizabeth Warren. This is a remarkably talented group of freshmen Senators, and we're glad to have them on board. I know that some are also over at Senator Kerry's hearing to be Secretary of State starting at the same time.

I also want to salute our new Ranking Member, Senator Alexander. He has long been a valuable member of this committee. I have appreciated my relationship with the former Ranking Member, Senator Enzi, and I look forward to the same kind of close collaboration and partnership with my good friend, Senator Lamar Alexander.

Today our committee will examine a range of issues surrounding mental healthcare in this country. The tragic shooting in Newtown, CT, last month brought the issue of mental healthcare to the forefront of public dialog. Many people across the Nation, including the President, have said that we need to take a long, hard look at access to mental health services across the country.

I am pleased to have this opportunity today to start that dialog with my colleagues and our panel of expert witnesses. I am told this is the first hearing that this committee of jurisdiction has had on this issue since 2007. So it's long overdue.

Certainly, one of the most insidious stereotypes about people with mental illness is that they are inherently violent. I regret that some of the discussion in the wake of the Newtown tragedy has sadly reinforced this stereotype. As my fellow committee members

know and our witnesses and experts know, people with mental illness are much more likely to be the victims of violent crimes than they are to be perpetrators of acts of violence.

Mental health conditions are sometimes called the Nation's silent epidemic. Mental illness affects one in four Americans every year. But, despite its prevalence, there is still a stigma attached with mental illness, and that stigma results in too many people suffering in silence without access to the care that could significantly improve their lives.

Stigma also can stop workers from requesting and getting accommodations that can help them be more productive at work. I've known so many instances of people who were afraid to do anything because they might lose their job or they wouldn't get promoted because of that stigma that's attached.

Like many other chronic diseases, mental health problems often begin at a young age. Experts tell us that half of all mental illness is manifested by age 14. However, less than half of children with an identified mental health condition receive treatment. And the average lag time from the first onset of symptoms to receiving treatment is almost a decade. Unfortunately, the picture for adults seeking treatment is not much better.

This lack of treatment has huge consequences. Some 30,000 Americans die by suicide each year. And it's a shocking fact that people with serious mental illnesses die significantly earlier than Americans overall, often from treatable causes like diabetes and smoking related chronic conditions.

These consequences also spill into other areas. As any teacher or school counselor will tell you, a child who is struggling with depression, anxiety, or any other mental health condition is also likely to struggle academically.

It's also an issue for our justice system since our prisons too often become the dumping ground for people who should be receiving mental health and substance abuse counseling instead. I have had a number of sheriffs in my own State, as well as other States, tell me that their jails are now the *de facto* mental institutions in their States.

The shame in this is that with access to the right treatments and supports, most people with mental illness can recover and lead productive and healthy lives. But we need to make the critical investments that will enable this to happen. So wearing my other hat as the chairman of the Labor, Health and Human Services, and Education Appropriations Subcommittee, I plan to take a close look at funding opportunities in this area through the appropriations process.

We've made important steps forward in recent years. My friend, the late Senator Paul Wellstone, and, again, along with my friend, Senator Pete Domenici, fought for years to try to enact the Mental Health Parity Act to end the absurd practice of treating mental and physical illnesses as two different things under health insurance. We finally passed it in 2008.

However, I am sad to say that it has been 4 years, 4 years now, that we do not have any final rules on implementing this law. That's a shame. I am told the President said that they will be announcing a final rule soon. I don't know what soon means, but I

hope it means what we generally take it to mean, which means soon.

Another critical step will take place next year when, thanks to the Affordable Care Act, some 30 million Americans will become eligible for Medicaid or private insurance through the healthcare exchanges. Coverage of mental health and substance abuse disorder services is 1 of the 10 essential benefits required in qualified health plans.

The insurance expansion here offers both challenges and opportunities. Experts predict that the newly insured population will have a greater need for mental health coverage than the general population. As we think about how to meet this need, there is an opportunity to realign our healthcare system to better integrate primary care and mental health services. And in reading over the testimony last evening of our witnesses, many of our witnesses spoke about that, this integration of primary care and mental health services.

This committee, I think, on both sides have been very supportive of the expansion of community health centers throughout the United States. They've been a great addition. They're wonderful primary care providers. But how do we integrate mental healthcare services in with those community health centers and make sure it's part of primary care?

President Kennedy signed the Community Mental Health Act of 1963, 50 years ago, which led to a major shift in mental healthcare in this country. People who were warehoused in institutions moved back into their communities. But the results were mixed. Many people were not able to access the community-based services and treatments they needed. So as we face major new changes in the healthcare landscape, I hope we'll learn from these lessons and, as I said, see how we might more fully utilize the community health center system in America to integrate primary care and mental health services.

So today we'll hear from a panel of expert witnesses who will talk about mental healthcare from a variety of perspectives, all with the goal, I hope, of addressing this critical but often neglected public health issue. I want to reemphasize that in my own words—public health issue.

So I thank you all for being here. I look forward to your testimony, and I'll yield to our Ranking Member, Senator Alexander.

## OPENING STATEMENT OF SENATOR ALEXANDER

Senator ALEXANDER. Thanks, Mr. Chairman. Thanks for your courtesy. I look forward to working with you. We've worked well together in the past. This is a very important committee with a large jurisdiction, and I am delighted to have a chance to be the Ranking Member.

I want to say to Senator Enzi how much I appreciate his leadership, and we expect it to continue as time goes along.

I also want to thank the chairman for having this hearing in the way he's having the hearing. We're entering this discussion, so far as I'm concerned—and that's my sense of the chairman's attitude—with no agenda other than to learn what needs to be done. As the

chairman said, we haven't had a mental health hearing for a while, so I'm here to do a lot of listening.

I was saying to some of the witnesses before the hearing that when I was U.S. Education Secretary, I often sat in their shoes, and I remember going back and telling the people in the Department that I thought I was going to a hearing, but, in fact, it was a talking, because the Senators did all the talking, and the witnesses did most of the listening. So I hope this will be more of a hearing instead of a talking, and I'll try to do my best to make it that way.

It seems to me that the question before us is: Who needs help, and who's there to provide the help? If we can hone in on that question and see what the Federal Government can do to improve our ability to determine who needs help and our ability to identify the person or agency whose job it is to provide the help, then we will have provided some service.

It helps to put a face on who needs help. As a former Governor, I always look at things from my own background and perspective, as I know most of us do. About 22 percent of Tennesseans reported having a mental illness last year. That's more than a million people. This is according to our State's Department of Mental Health. About 5 percent had a severe mental illness. That's nearly a quarter of a million Tennesseans. So that's a lot of people. About 41,000 Tennesseans had a major depressive episode.

The funding that helps meet the needs for that comes in some part from the Federal Government. About 22 percent of what Tennessee spends, I'm told, is Federal dollars. The rest is State dollars. In the community services, State appropriations are about 70 percent of the mental health funds. So while the Federal Government has a role here, it's a support role and a supplementary role, and it's a role that ought to make things easier instead of harder.

In preparing for this, it seems to me that, putting a face on the individuals who need help, one group would be a 9-year-old boy who has always been pleasant but suddenly started defying his teachers. His grades slipped, and he didn't want to go to Boy Scouts. He didn't want to play with friends. So they reached out to a pediatrician who was able to get some professional assistance. He was diagnosed with a mood disorder and he began to improve with sleeping better. And so it was a success story for that 9-year-old boy.

Another case might be an adolescent, a 17-year-old, who had no behavioral issues growing up. He started noticing lights in the bathroom. Sounds of water irritated him. He had trouble sleeping. He began to hear voices telling him to throw rocks at anyone who told him to come down from the roof. And he was finally diagnosed with schizophrenia, but only after he had multiple episodes.

Those two boys represent two of the largest groups that need help. And I'll be interested in finding out from our witnesses how well we're doing in helping them get the help.

Finally, I'll be especially interested in asking the Federal agencies as well as the State and local witnesses who are here what we can do at the Federal level to make things easier to, No. 1, identify who needs help, and, No. 2, identify who can provide the help. Are there administrative things we can do? Are there funding things

we can do? Are we putting up any roadblocks that make it harder for you to provide services? If we are, this is the place to identify them and see if we can correct them.

So, Mr. Chairman, I look forward to this. I thank you for holding the hearing.

The CHAIRMAN. Thank you very much, Senator Alexander.

Now we'll turn to our witnesses. We have two panels. On our first panel, we'll start with Pamela S. Hyde, the Administrator of the Substance Abuse and Mental Health Services Administration, obviously known as SAMHSA to all of us. Ms. Hyde was nominated by President Obama and confirmed by the U.S. Senate in November 2009 as the Administrator of SAMHSA. She is an attorney and comes to SAMHSA with more than 30 years of experience in management and consulting for public healthcare and human service agencies.

She has 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 health firm. Ms. Hyde is a member of or has served as a consultant to many national organizations, including the John D. and Catherine T. MacArthur Foundation, the American College of Mental Health Administration, the President's New Freedom Commission on Mental Health, and the U.S. Department of Justice.

Our second witness on this panel, of course, is no stranger to this committee, or at least to my Appropriations Subcommittee. Dr. Thomas Insel, who is the Director of the National Institute of Mental Health, NIMH, at the National Institutes of Health. He has been director since the fall of 2002. Prior to that, Dr. Insel was a professor of psychiatry at Emory University, and there he was the founding director of the Center for Behavioral Neuroscience, one of the largest science and technology centers funded by the National Science Foundation.

He has published over 250 scientific articles and four books, including *The Neurobiology of Parental Care* in 2003. He is a member of the Institute of Medicine, a fellow of the American College of Neuropsychopharmacology—there, I said it—and is a recipient of several awards, including the Outstanding Service Award from the U.S. Public Health Service.

We thank you both for your backgrounds, for what you have done in this whole area of mental health both in research and practicality. And your statements will be made a part of the record in their entirety. We'll start with Ms. Hyde. I would ask that you sum it up in 5 to 8 minutes, and then we'll get to some questions. Again, welcome.

Ms. Hyde, please proceed.

**STATEMENT OF PAMELA HYDE, J.D., ADMINISTRATOR, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, ROCKVILLE, MD**

Ms. HYDE. Thank you, Chairman Harkin and Ranking Member Alexander, for holding this hearing today. It's an important day.

You will hear today about the prevalence and burden of mental illness and about the critical need in our country for understanding, treatment, and support services for those who experience

mental health conditions. SAMHSA's mission is to reduce the impact of both substance abuse and mental illness in America's communities, and there is significant overlap between those two sets of conditions. They currently exist largely outside the mainstream of American healthcare, with different histories, structures, funding, incentives, practitioners, and even, in some cases, different governing laws.

It's time that changed. SAMHSA envisions a nation that understands and acts on the knowledge that behavioral health is really essential to health, that mental and emotional health and freedom from substance abuse and addiction are necessary for an individual, a family, or a community to be healthy.

As the Senator said, almost half of all Americans will experience symptoms of mental or substance abuse disorders in their lifetime, and yet of the over 45 million adults with any mental illness in a given year, only 38.5 percent of them receive the treatment they need. And of the almost 22 million adults with substance abuse disorders, only about 11 percent receive the treatment they need. For children and adolescents, it's only about one in five that receive the treatment they need for diagnosable mental disorders.

Cost, access, and recognition of the problems are the primary reasons this treatment is not received. However, it doesn't have to be this way. For most of these conditions, prevention works, treatment is effective, and people do, in fact, recover. As Senator Harkin said, the Institute of Medicine reported in 2009 that half of adult mental illness begins before the age of 14 and three-quarters before the age of 24.

We can and must intervene early to address these issues for our young people and for our Nation. Behavioral health is a public health issue, not a social issue, and it can be tackled and addressed in an effective public health approach driven by data focused on prevention and supportive policies and services that treat and restore to health.

I'd like to talk about the Affordable Care Act for just a minute, because it's going to provide one of the largest expansions of mental health and substance abuse coverage in a generation by helping over 65 million Americans have access to additional behavioral health benefits that they do not have now. The ACA has already provided screening for depression, suicide risk, and alcohol misuse in many service programs and in its quality measures, and it has already provided additional coverage opportunities for youth. It will ensure that insurance plans offered in the new marketplaces cover mental and substance abuse disorders at parity with other benefits and as 1 of the 10 essential health benefit categories.

As part of the President's plan to protect our children and our communities, he outlines some specific actions and initiatives. To help ensure adequate coverage of mental health and addiction services, the Administration issued a letter to State health officials making it clear that Medicaid expansion plans must comply with the parity requirements of the Mental Health Parity and Addictions Equity Act of 2008, or what we call MHPAEA.

In addition, the Administration will issue final regulations governing how existing health plans that offer mental health and addiction services must cover them at parity under MHPAEA. The

President's initiatives to ensure students and young adults receive treatment for mental health issues include SAMHSA-led proposals such as a new program called Project Aware, which would bring together State officials, schools, communities, families, and youth to promote safety, prevent violence, and to identify mental and behavioral health conditions early and refer young people to treatment. Project Aware would also provide mental health first aid training.

A proposed new grant program, Healthy Transitions, would provide a pilot to model innovative State and community-based initiatives and strategies supporting young people ages 16 to 25. Along with HRSA, the President's workforce proposal would provide training for more than 5,000 additional mental health professionals to serve students and young adults.

Finally, with the Department of Education, HHS will soon launch what we're calling a national dialog on mental health to help change the conversation and galvanize action about our children's mental health.

We've come a long way in the prevention, treatment, and recovery supports for mental and addictive disorders. But we have a long way to go, and we can do better.

Thank you for your time today, and I'd be very pleased to answer any questions that you may have.

[The prepared statement of Ms. Hyde follows:]

PREPARED STATEMENT OF PAMELA S. HYDE, J.D.

Chairman Harkin, Ranking Member Alexander and members of the Senate Health, Education, Labor, and Pensions Committee, thank you for inviting me to testify at this important hearing on the state of the mental health system. I am pleased to testify along with Dr. Insel on the state of America's mental health system and to discuss some of the initiatives related to mental health included in the President's plan to protect our children and our communities.

THE SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (SAMHSA)

As you are aware, the Substance Abuse and Mental Health Services Administration's (SAMHSA) mission is to reduce the impact of substance abuse and mental illness on America's communities. SAMHSA envisions a Nation that acts on the knowledge that:

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

In order to achieve this mission, SAMHSA has identified eight Strategic Initiatives to focus the Agency's work on improving lives and capitalizing on emerging opportunities. SAMHSA's top Strategic Initiatives are: Prevention; Trauma and Justice; Health Reform; Military Families; Recovery Supports; Health Information Technology; Data, Outcomes and Quality; and Public Awareness and Support.

PREVALENCE OF BEHAVIORAL HEALTH CONDITIONS AND TREATMENT

In the wake of the Newtown tragedy, 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.[1] Studies indicate that people with mental illnesses are more likely to

[1] 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.

be the victims of violent attacks than the general population.[2] In fact, demographic variables such as age, gender and socioeconomic status are more reliable predictors of violence than mental illness.[3] These facts are important because misconceptions about mental illness can cause discrimination and unfairly hamper the recovery of the nearly 20 percent of all adult Americans who experience a mental illness each year.

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.[4] And according to data from SAMHSA's National Survey on Drug Use and Health (NSDUH), only 38 percent of adults with diagnosable mental health problems—and only 11 percent of those with diagnosable substance use disorders—receive needed treatment.[5]

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.[6] When persons with mental health conditions or substance use disorders do not receive the proper treatment and supportive services they need, crisis situations can arise affecting individuals, families, schools, and communities. We need to do more to identify mental health and substance abuse issues early and help individuals get the treatment they need before these crisis situations develop. And we need to help communities understand and implement the prevention approaches we know can be effective in stopping issues from developing in the first place.

The President's announcement includes several important steps to help address mental health prevention and treatment. I look forward to the opportunity to discuss these with you.

### MENTAL HEALTH FINANCING

First, however, I will provide some background on mental health financing. The National Expenditures for Mental Health Services and Substance Abuse Treatment report for 1986–2005 found that $113 billion was spent on mental health and $22 billion for substance abuse services in 2005. SAMHSA is in the process of updating this data. In 2005, spending on mental health services accounted for 6.1 percent of all-health spending. Public payers accounted for 58 percent of mental health spending and 46 percent of all-health spending. Medicaid (28 percent of mental health spending) and private insurance (27 percent of mental health spending) accounted for more than half of mental health spending in 2005, followed by other State and local government at 18 percent, Medicare at 8 percent, out-of-pocket at 12 percent, other Federal at 5 percent and other private sources at 3 percent.

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[2] 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, 2110–12.

[3] Elbogen, E.B., Johnson, S.C. Arch Gen Psychiatry. 2009 Feb;66(2):152–61. doi: 10.1001/archgenpsychiatry.2008.537.

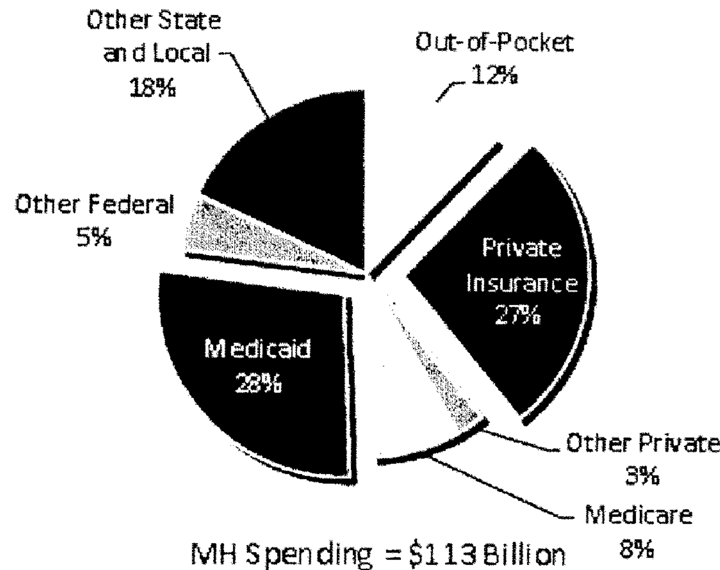
The intricate link between violence and mental disorder: results from the National Epidemiologic Survey on Alcohol and Related Conditions.

[4] 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;159:1548–55. 10.1176/appi.ajp.159.9.1548.

[5] 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.

[6] 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.




The National Expenditures report also found prescription drugs accounted for the largest share of mental health spending in 2005—27 percent. Mental health drug spending grew by an average of 24 percent a year between 1997 and 2001. After 2001, growth slowed dramatically, to an average rate of 10 percent a year between 2001 and 2005.

A key source of funding for services for adults with serious mental illness (SMI) and children with severe emotional disturbances (SED) is the Community Mental Health Services Block Grant (MHBG), which is a flexible funding source that is used by States to provide a range of mental health services described in their plans for comprehensive community-based mental health services for children with serious emotional disturbance and adults with serious mental illness. These funds are used to support service delivery through planning, administration, evaluation, educational activities, and services. Services 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. The State plan is developed in collaboration with the State mental health planning councils. Planning Councils' membership is statutorily mandated to include consumers, family members of adult and child consumers, providers, and representatives of other principal State agencies. The fiscal year 2013 President's budget proposed $460 million to continue the MHBG.

SAMHSA also administers the Substance Abuse Prevention and Treatment Block Grant (SABG) for the States. The fiscal year 2013 President's budget proposed $1.4 billion for the SABG, and $400 million for primary prevention of substance abuse.

According to the National Association of State Mental Health Program Directors, over the past few years, States and communities have significantly reduced funding for mental health and addiction services. They estimate that in the last 4 years, States have cut $4.35 billion in mental health services, while an additional 700,000 people sought help at public mental health facilities during this period.[7] These changes have occurred despite the evidence that early treatment and prevention for

[7] The National Association of State Mental Health Program Directors (NASMHPD). *Too Significant To Fail: The Importance of State Behavioral Health Agencies in the Daily Lives of Americans with Mental Illness, for Their Families, and for Their Communities*. Alexandria, VA. 2012.

mental illness and substance use programs can reduce health costs, criminal and juvenile justice costs, and educational costs, and increase productivity.[8]

Additionally, investments in these programs and services can help reduce physical health costs for those with co-morbid health and behavioral health conditions.[9] Some States have found that providing adequate mental health and addiction-treatment benefits can dramatically reduce health care costs and Medicaid spending.

## ADVANCEMENTS AND TRENDS IN BEHAVIORAL HEALTH

### *Community-Based Care*

In 1963, President John F. Kennedy signed into law the Mental Retardation Facilities and Community Mental Health Centers Construction Act. The Act led to a drastic alteration in the delivery of mental health services and establishment of more than 750 comprehensive community mental health centers throughout the country. This movement to community-based services helped to reduce the number of individuals with mental illness who were "warehoused" in secluded hospitals and isolated institutions. Other advancements in the treatment of mental illness and the growth of the recovery movement, along with other programs such as supportive housing, assertive community treatment teams, peer specialists, supportive employment, and social security disability payments, have helped provide the services and supports necessary for persons with serious mental illness to survive and thrive in the community. Experience and research has shown that the goal of recovery is exemplified through a life that includes: Health; Home; Purpose and Community.[10] Peers play an important role in recovery support and the consumer movement has helped promote not only the idea that recovery is possible, but also those consumers should play a key role in their recovery. SAMHSA's Recovery Support Initiative partners with people in recovery from mental and substance use disorders and family members to guide the behavioral health system and promote individual-, program-, and system-level approaches that foster health and resilience; increase permanent housing, employment, education, and other necessary supports; and reduce discriminatory barriers.

### *Integration*

Given that behavioral health is essential to an individual's overall health, SAMHSA administers the Primary and Behavioral Health Care Integration (PBHCI) program. The purpose of the program is to improve the physical health status of people with serious mental illnesses (SMI) 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 SMI and co-occurring SMI and substance use disorders. It is a program focused on increasing the health status of individuals based on physical or behavioral need. The program encourages structural changes in existing systems to accomplish its goals. To date, the program has awarded 94 grants and 55 percent of awardees are partnering with at least one Federally Qualified Health Center (FQHC). This integration results in significant physical and behavioral health gains. PBHCI grantees collect data on patients at admission and in followup reassessments every 6 months, as well as at discharge when possible. 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).

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[8] National Research Council. Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities. Washington, DC: The National Academies Press, 2009.

[9] See e.g., Egede, L.E., Zheng, D., & Simpson, K. (2002). Comorbid depression is associated with increased health care use and expenditures in individuals with diabetes. Diabetes Care, 25(3), 464–470.

[10] New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America. Final Report*. DHHS Pub. No. SMA–03–3832. Rockville, MD: 2003.

• Blood pressure (categorical): Among 7,493 clients, 18.3 percent showed improvement, and 16.7 percent are no longer at risk for high blood pressure (systolic less than 130, diastolic less than 85).

• BMI: Among 7,120 clients, 45.6 percent showed improvement, and 4.8 percent are no longer at risk for being overweight (BMI less than 25).

Service systems that are aligned with patient and client need, specifically those providing integrated treatment, produce better outcomes for individuals with co-occurring mental and substance use disorders.[11] Without integrated treatment, one or both disorders may not be addressed properly. Mental health and substance abuse authorities across the country are taking steps to integrate systems and services, and promote integrated behavioral health treatment. Currently, there are 35 States that have a combined mental health and substance abuse authority. In addition, at least two additional States and the District of Columbia are moving toward a single agency.

SAMHSA continues to work with both States and grantees to encourage systems collaboration and coordination to develop mental health and substance abuse systems that support seamless service delivery. SAMHSA's effort to integrate primary care and mental health and substance abuse services offers a promising, viable, and efficient way of ensuring that people have access to needed behavioral health services. Additionally, behavioral health care delivered in a primary care setting can help to minimize discrimination and reduce negative attitude about seeking services, while increasing opportunities to improve overall health outcomes. Leadership supporting this type of coordinated quality care requires the support of a strengthened behavioral health and primary care delivery system as well as a long-term policy commitment.

*Mental Health Parity and Addiction Equity Act (MHPAEA)*

In 2008, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) became law. MHPAEA improves access to much-needed mental and substance use disorder treatment services through more equitable coverage. The law applied to large group health plans (sponsored by employers with more than 50 employees) and health insurance issuers that offered coverage in the large group market. The law requires that plans and issuers that offer coverage for mental illness and substance use disorders provide those benefits in a way that is no more restrictive than the predominant requirements or limitations applied to substantially all medical and surgical benefits covered by the plan.

*Affordable Care Act*

The Affordable Care Act advances the field of behavioral health by expanding access to behavioral health care; growing the country's behavioral health workforce; reducing behavioral health disparities; and implementing the science of behavioral health promotion.

While most mental illnesses and addictions are treatable, those with mental illness often cannot get needed treatment if they do not have health insurance that covers mental health services. The Affordable Care Act will provide one of the largest expansions of mental health and substance abuse coverage in a generation by extending health coverage to over 30 million Americans, including an estimated 6 to 10 million people with mental illness. It also includes coverage for preventive services, including screening for depression and alcohol misuse. The Affordable Care Act will also make sure that Americans can get the mental health treatment they need by ensuring that insurance plans in the new Marketplaces cover mental health and substance abuse benefits at parity with other benefits. Beginning in 2014, all new small group and individual plans will cover mental health and substance use disorder services, including behavioral health treatment.

Medicaid is already the largest payer of mental health services, and the Affordable Care Act will extend Medicaid coverage to as many as 17 million hardworking Americans.

SAMHSA's No. 1 strategic initiative is Prevention of Substance Abuse and Mental Illness, and the Agency has also been heavily engaged in the implementation of the prevention and public health promotion provisions of the Affordable Care Act. For example, the National Prevention Strategy includes priorities focused on Mental and Emotional Well-Being and Preventing Drug Abuse and Excessive Alcohol Use.

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[11] Center for Substance Abuse Treatment. Systems Integration. COCE Overview Paper 7. DHHS Publication No. (SMA) 07–4295. Rockville, MD: Substance Abuse and Mental Health Services Administration, and Center for Mental Health Services, 2007.

MOVING FORWARD

Moving forward, in the wake of the tragedy in Newtown, CT, the Administration is focused on making sure that students and young adults get treatment for mental health issues. At the same time, SAMHSA knows that a larger national dialogue about mental health in America needs to occur and we will be taking steps to foster this dialog.

*Parity*

The Administration intends to issue next month the Final Rule on defining essential health benefits and implementing requirements for new small group and individual plans to cover mental health benefits at parity with medical and surgical benefits. In addition, the President announced that the Administration is committed to promulgating a MHPAEA Final Rule.

Last week, the Centers for Medicare and Medicaid Services sent a State Health Official Letter regarding the applicability of MHPAEA to Medicaid non-managed care benchmark and benchmark-equivalent plans (referred to in this letter as Medicaid Alternative Benefit plans) as described in section 1937 of the Social Security Act (the Act), the Children's Health Insurance Programs (CHIP) under title XXI of the Act, and Medicaid managed care programs as described in section 1932 of the Act.

*Reaching Youth and Young Adults*

As I noted earlier, three-quarters of mental illnesses appear by the age of 24, yet less than one in five children and adolescents with diagnosable mental health and substance use problems receive treatment. That is why last week, the President announced initiatives to ensure that students and young adults receive treatment for mental health issues. Specifically, SAMHSA will take a leadership role in initiatives that would:

- **Reach 750,000 young people through programs to identify mental illness early and refer them to treatment:** We need to train 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 is calling for a new initiative, Project AWARE (Advancing Wellness and Resilience in Education), to provide this training and set up systems to provide these referrals. This initiative has two parts:
    - **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 in children and young adults, including how to encourage adolescents and families experiencing these problems to seek treatment.
    - **Make sure students with signs of mental illness get referred to treatment:** Project AWARE also proposes $40 million to help school districts work with law enforcement, mental health agencies, 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 improve mental health.
- **Support individuals ages 16 to 25 at high risk for mental illness:** 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 turn 18. The Administration is proposing $25 million for innovative State-based strategies supporting young people ages 16 to 25 with mental health or substance abuse issues.
- **Train more than 5,000 additional mental health professionals to serve students and young adults:** Experts often cite the shortage of 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, and other mental health professionals. This would provide stipends and tuition reimbursement to train more than 5,000 mental health professionals serving young people in our schools and communities.

*National Dialogue*

Finally, we know that it is time to change the conversation about mental illness and mental health in America. HHS is working to develop a national dialog on the mental and emotional health of our young people, engaging parents, peers, and teachers to reduce negative attitudes toward people with mental illness, to recognize the warning signs, and to enhance access to treatment.

CONCLUSION

Thank you again for this opportunity to discuss the state of America's mental health system. I would be pleased to answer any questions that you may have.

The CHAIRMAN. Thank you very much, Dr. Hyde.

Now we'll turn to Dr. Insel. Welcome again and please proceed.

**STATEMENT OF THOMAS INSEL, M.D., DIRECTOR, NATIONAL INSTITUTE OF MENTAL HEALTH AT THE NATIONAL INSTITUTES OF HEALTH, BETHESDA, MD**

Dr. INSEL. Thank you, Mr. Chairman and Ranking Member Alexander and members of the committee. It's a real honor to be here, and it's actually a great pairing to have Administrator Hyde and me on the same panel.

This is essentially going from services to science. So as a person coming to you from the National Institute of Mental Health and the National Institutes of Health, my role is really around the research related to mental illness and thinking about how to come up with the science that will lead to better diagnostics, better therapeutics, better understanding of what you called a silent epidemic, Senator Harkin. And that's actually an interesting term for this.

I know we haven't met for some years to talk about this. So it's particularly, for us, important to get this out on the agenda. It's clear that in some ways this is a response to this tragic event that happened in December in Newtown, CT. And if it takes an event like that to focus the Nation's attention on the needs of those with mental illness—it's terrible to say that, but at least perhaps one of the opportunities that can be taken now is to think about how do we do better by those with mental illness and how do we make sure that events like this don't happen again.

I'm not going to read my testimony to save time. I think both Pam and I are eager to get to your questions. But perhaps to preempt some of those questions, let me take just a couple of minutes to make some of the points that might help in terms of how we think about mental illness, some of the definitions and the science as we understand it.

First of all, when we talk about mental illness, we're talking about, as you have already heard, very common disorders, depression, PTSD, eating disorders, and there are many others. There are about 10 or 12 that we focus on. These are real illnesses with real treatments and affect about one in five Americans overall, including youth, as we'll say in a moment.

Today, we're probably going to talk mostly about serious mental illness. That's a term of art that has to do with those people who are truly disabled, often by a psychotic illness. That occurs in about, overall, perhaps 1 in 20. So it's not quite as common. But it's an important piece of the story that we need to talk about, because these are the people who are most severely impaired.

As Pam mentioned and as already mentioned by you, Senator Harkin, it's really critical for the committee to understand that unlike talking about cancer and diabetes and heart disease, when we talk about mental illness, we're talking about illnesses that begin early in life. These are, in fact, the chronic disorders of young people, and it requires a different mindset when you think about how

do you detect, how do you intervene, how do you make sure that you can make a difference. That's one of the reasons why these disorders have the highest disability rating or the highest morbidity overall. It's because they start early and they tend to be chronic.

As Pam mentioned, we know these are treatable disorders, but there's a significant delay in getting treatment. And even in those young people who have these most severe illnesses like schizophrenia, on average, the delay between the onset of symptoms and when they get diagnosed and treated is somewhere between 1 and 2 years, which seems extraordinary because you're talking about symptoms that are so disabling and so obvious.

And it's especially unfortunate, because the lesson we have learned from cancer and heart disease, diabetes and AIDS, is that the secret to having the best outcomes is early detection and early intervention. That's what biomedical research has taught us over the last four decades. You have to get there early in the process if you want people to have the best outcome, and we don't do that here.

I think one of the things we need to talk about—again, going back to your comments, Senator Alexander, about who needs help and who's going to be responsible for providing help—is why the delay, and how do we do better in making sure that people get involved earlier in the process.

Just a comment about violence and mental illness, because it will come up, I think. It's on a lot of people's minds. As you've heard already, most violence has nothing to do with mental illness, and most people with mental illness are not violent. In fact, we generally worry more about people with mental illness, especially severe mental illness, being the victims, not the perpetrators, of violence, and the science certainly supports that.

There are two conditions where we do need to think about this because violence and mental illness will intersect. And one of those is the psychotic illnesses like schizophrenia that start early in usually adolescents. For people who have not received treatment, they are at greater risk for violence, either because they are paranoid and may irrationally feel that they are under attack, or sometimes because of hallucinations or voices telling them to do something horrific, as you mentioned with your example, Senator Alexander.

Far more common, however, is the second issue. It's not homicide or violence against others. It's violence against the self. Suicide is a far more common problem for people with serious mental illness—38,000 suicides in this country each year with the most recent data that we have. That's more than 1 every 15 minutes. Of these, 90 percent involve mental illness. By contrast, there are less than 17,000 homicides, with less than 5 percent involving mental illness.

So when we talk about violence and mental illness, when we talk about safety and security, when we talk about access to means or duty to warn, the bigger problem here is suicide. It's protecting the person with mental illness as well as family members, peers, and people in the community.

There's a lot that can be done here. We're not great at predicting. It's still more an art than science. And I would say that's true, by the way, of heart attack, cancer, as well as serious mental illness

or violence in those people who are affected by these kinds of illnesses.

But even without being 100 percent certain on the predictions at the individual level, we can do a lot toward prevention, and you'll hear something about that in the conversation today. At NIMH, we've really spent much of our investments focusing on the earliest stages of severe mental illness and identifying high-risk states before psychosis begins, just the way we do today with cancer and heart disease and thinking about how to intervene early.

So I think I will stop there except to say that this is an extraordinary time in terms of the science of mental illness. We are really in the middle of a revolution because of what we're learning about the brain. We do think about each of these disorders as brain disorders, and we think about our interventions in terms of how they affect individual brain circuits.

We've made tremendous strides over the last 50 years. You cited President Kennedy's launching of the Community Mental Health Program, which actually began with a special comment to Congress on February 5, 1963. So we're almost exactly at the 50-year anniversary. A lot has happened in that time, but as Pam mentioned, we have a long way to go. I look forward to your questions about how we can do better going forward.

Thank you.

[The prepared statement of Dr. Insel follows:]

### PREPARED STATEMENT OF THOMAS INSEL, M.D.

Mr. Chairman and members of the committee, I am Thomas R. Insel, M.D., director of the National Institute of Mental Health (NIMH) at the National Institutes of Health, an agency in the Department of Health and Human Services. Thank you for this opportunity to present an overview of the current state of mental health research at NIMH, with a particular focus on our efforts to address serious mental illness, and our efforts to discover, develop, and pursue new treatments for these brain disorders. In my statement, I will review the scope of mental disorders in the United States and their impact on public health, and I will outline examples of NIMH's research efforts designed to address this challenge.

#### PUBLIC HEALTH BURDEN OF MENTAL ILLNESS

The National Institute of Mental Health is the lead Federal agency for research on mental disorders, with a mission to transform the understanding and treatment of mental illnesses through basic and clinical research. The burden of mental illness is enormous. In the United States, an estimated 11.4 million American adults (approximately 4.4 percent of all adults) suffer from a serious mental illness (SMI) each year, including conditions such as schizophrenia, bipolar disorder, and major depression.[1] According to a 2004 World Health Organization report, neuropsychiatric disorders are the leading cause of disability in the United States and Canada, accounting for 28 percent of all years of life lost to disability and premature mortality (Disability Adjusted Life Years or DALYs).[2] The personal, social and economic costs associated with these disorders are tremendous. Suicide is the 10th leading cause of death in the United States, accounting for the loss of more than 38,000 American

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[1] Substance Abuse and Mental Health Services Administration. *Results from the 2009 National Survey on Drug Use and Health: Mental Health Findings* (Office of Applied Studies, NSDUH Series H–39, HHS Publication No. SMA 10–4609). Rockville, MD: Substance Abuse and Mental Health Services Administration, 2010.

[2] The World Health Organization. *The global burden of disease: 2004 update*, Table A2: Burden of disease in DALYs by cause, sex and income group in WHO regions, estimates for 2004. Geneva, Switzerland: WHO, 2008.

lives each year, more than double the number of lives lost to homicide.[3] A cautious estimate places the direct and indirect financial costs associated with mental illness in the United States at well over $300 billion annually, and it ranks as the third most costly medical condition in terms of overall health care expenditure, behind only heart conditions and traumatic injury.[4 5] Even more concerning, the burden of illness for mental disorders is projected to sharply increase, not decrease, over the next 20 years.[6]

NIMH-supported research has found that Americans with SMI die 8 years earlier than the general population.[7] People with SMI experience chronic medical conditions and the risk factors that contribute to them more frequently and at earlier ages. There are low rates of prevention, detection, and intervention for chronic medical conditions and their risk factors among people with SMI, and this contributes to significant illness and earlier death. Two-thirds or more of adults with SMI smoke[8]; over 40 percent are obese (60 percent for women)[9 10]; and metabolic syndrome is highly prevalent, especially in women.[11] Approximately 5 percent of individuals with schizophrenia will die by suicide during their lifetime, a rate 50-fold greater than the general population. [12]

DELAYS IN RECEIVING TREATMENT—AND THE CONSEQUENCES

According to a study published in 2004, the vast majority (80.1 percent) of people having any mental disorder eventually make contact with a health care professional to receive treatment, although delays to seeking care average more than a decade.[13] Although instances of SMI are associated with shorter delays, the average delay was nevertheless approximately 5 years—that is 5 years of increased risk for using potentially life-threatening, self-administered treatments, such as legal or illicit substances, or even death. During an episode of psychosis, people can lose touch with reality and experience hallucinations and delusions. Research has suggested that persons with schizophrenia whose psychotic symptoms are controlled are no more violent than those without SMI.[14] Nonetheless, when untreated psychosis is also accompanied by symptoms of paranoia and when it is associated with substance abuse, the risk of violence is increased. Importantly, the risk of violence is reduced with appropriate treatment. Moreover, people with SMI are 11 times more likely than the general population to be victims themselves of violence.[15]

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[3] Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS): *www.cdc.gov/ncipc/wisqars* accessed November 2011.

[4] Insel TR. Assessing the economic cost of serious mental illness. *Am J Psychiatry*. 2008 Jun;165(6):663–5.

[5] Soni A. *The Five Most Costly Conditions, 1996 and 2006: Estimates for the U.S. Civilian Noninstitutionalized Population*. Statistical Brief #248. July 2009. Agency for Healthcare Research and Quality, Rockville, MD.

[6] Bloom DE, Cafiero ET, Jané-Llopis E, Abrahams-Gessel S, Bloom LR, Fathima S, Feigl AB, Gaziano T, Mowafi M, Pandya A, Prettner K, Rosenberg L, Seligman B, Stein A, Weinstein C. *The Global Economic Burden of Non-communicable Diseases*. Geneva, Switzerland: World Economic Forum, 2011.

[7] Druss BG, Zhao L, Von Esenwein S, Morrato EH, Marcus SC. Understanding excess mortality in persons with mental illness: 17-year followup of a nationally representative U.S. survey. *Med Care*. 2011 Jun;49(6):599–604.

[8] Goff DC, Sullivan LM, McEvoy JP, ET al. A comparison of 10-year cardiac risk estimates in schizophrenia patients from the CATIE study and matched controls. *Schizophrenia Res*. 2005;80(1):45–53.

[9] Allison DB, Fontaine KR, Heo M, ET al. The distribution of body mass index among individuals with and without schizophrenia. *J Clin Psych*. 1999;60(4):215–20.

[10] McElroy SL. Correlates of overweight and obesity in 644 patients with bipolar disorder. *J Clin Psych*. 2002;63:207–213.

[11] McEvoy JP, Meyer JM, Goff DC, ET al. Prevalence of the metabolic syndrome in patients with schizophrenia: Baseline results from the (CATIE) schizophrenia trial and comparison with national estimates from NHANES III. *Schizophrenia Res*. 2005;80(1):19–32.

[12] Hor K. & Taylor M. Suicide and schizophrenia: a systematic review of rates and risk factors. *J Psychopharmacol*. 2010;24(4S): 81–90.

[13] Wang PS, Berglund PA, Olfson M, Kessler RC. Delays in initial treatment contact after first onset of a mental disorder. *Health Serv Res*. 2004 Apr;39(2):393–415.

[14] Steadman HJ, Mulvey EP, Monahan J, Robbins PC, Appelbaum PS, Grisso T, Roth LH, Silver E. Violence by people discharged from acute psychiatric inpatient facilities and by others in the same neighborhoods. *Arch Gen Psychiatry*. 1998 May;55(5):393–401.

[15] Teplin, LA, McClelland, GM, Abram, KM & Weiner, DA. Crime victimization in adults with severe mental illness: comparison with the National Crime Victimization Survey. *Arch Gen Psychiatry*, 2005, 62(8), 911–921.

HOW NIMH IS ADDRESSING THIS PUBLIC HEALTH CHALLENGE

In the past, we viewed mental disorders as chronic conditions defined by their apparent symptoms, even though behavioral manifestations of illness are in fact the last indications—following a cascade of subtle brain changes—that something is wrong. We understand now that mental disorders are brain disorders, with specific symptoms rooted in abnormal patterns of brain activity. Moving forward, NIMH aims to support research on earlier diagnosis and quicker delivery of appropriate treatment, be it behavioral or pharmacological. NIMH has a three-pronged research approach to achieve this aim: (1) optimize early treatment to improve the trajectory of illness in people who are already experiencing the symptoms of SMI; (2) understand and prevent the transition from the pre-symptomatic (prodrome) phase to actual illness; and (3) investigate the genetic and biological mechanisms underlying SMI in order to understand how, in the future, we can preempt illness from ever occurring. Here are examples of NIMH efforts on these three fronts:

(1) In the United States, the delay between a first episode of psychosis and onset of treatment ranges from 61 to 166 weeks, with an average of 110 weeks.[16] NIMH seeks to reduce that delay as much as possible, through continued support of the Recovery After an Initial Schizophrenia Episode (RAISE) project; a large-scale research project to explore whether using early and aggressive treatment will reduce the symptoms and prevent the gradual deterioration of functioning that is characteristic of chronic schizophrenia. The project is currently focused on maintaining the quality of the treatment over time, and retaining individuals in treatment. Results from initial analyses suggest that a RAISE-type intervention would not only produce superior clinical outcomes, but will reduce re-hospitalization during the first year.

(2) NIMH is continuing to fund research directed at the prodromal phase of schizophrenia, the stage just prior to full psychosis. A consortium of eight clinical research centers (North American Prodrome Longitudinal Study or NAPLS) are using biological assessments, including neuroimaging, electrophysiology, neurocognitive testing, hormonal assays, and genomics, to improve our ability to predict who will convert to psychosis, and to develop new approaches to pre-emptive intervention.

(3) For decades, we have known that schizophrenia has a genetic component, but different methods for studying genetic changes have led to uncertainty about which genes are involved and how they contribute to illness. Using a new method to integrate information about illness-related genes from different types of studies, NIMH-supported researchers have identified a network of genes that affect the development, structure, and function of brain cells. The researchers detected important variations in how these gene-related brain changes affected risk for schizophrenia versus other disorders.[17]

PREEMPTION: THE FUTURE OF MENTAL HEALTH RESEARCH

Research has taught us to detect diseases early and intervene quickly to preempt later stages of illness. This year we will avert 1.1 million deaths from heart disease because we have not waited for a heart attack to diagnose and treat coronary artery disease.[18] The 100,000 young Americans who will have a first episode of psychosis this year will join over 2 million with schizophrenia. Our best hope of reducing mortality from this, other SMI, and other brain disorders will come from realizing that just like other medical disorders, we need to diagnose and intervene before the symptoms become manifest. The health of the country cannot wait.

The CHAIRMAN. Thank you, Dr. Insel. Now I'll start a round of 5-minute questions.

Ms. Hyde, I just want to focus on the Mental Health Parity and Addiction Equity Act signed into law in 2008—a major accomplishment. I am concerned because the interim final rule published in

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[16] Marshall M, Lewis S, Lockwood A, Drake R, Jones P, Croudace T. Association between duration of untreated psychosis and outcome in cohorts of first-episode patients. *Arch Gen Psychiatry*. 2005 Sep 62:975–83.

[17] Gilman SR, Chang J, Xu B, Bawa TS, Gogos JA, Karayiorgou M, Vitkup D. Diverse types of genetic variation converge on functional gene networks involved in schizophrenia. *Nat Neurosci*. 2012 Nov;15(12):1723–8.

[18] Vital Statistics of the United States, CDC/National Center for Health Statistics. (2011, August). Age-adjusted Death Rates for Coronary Heart Disease (CHD). National Heart Lung and Blood Institute. Retrieved January 23, 2013, from *http://www.nhlbi.nih.gov/news/spotlight/success/conquering-cardiovascular-disease.html*.

2010 left some implementation details unresolved. When the Administration publishes a final rule, how will you address issues such as the scope of services that must be covered so that insurers have the detailed guidance they need to implement the law?

Ms. HYDE. Thank you for the question, Senator Harkin. As you know, the interim final rule was published in 2010. Part of what was requested from the public was input on several topics. That was one. In the meantime, we've issued four or five subregulatory guidance frequently asked questions. We've also been meeting with stakeholders and with industry, trying to understand how the implementation is happening. We are ready to produce a final reg, and we're in that process now.

The CHAIRMAN. Thank you.

Dr. Insel, I have some concerns—I know others have also, and I've read a lot about these concerns, and I hear them from constituents and other people who talk to me—about the use of pharmaceuticals, particularly antipsychotic medications in children. What I hear is sometimes a kid acts up and does something—get them a drug. Get them some antipsychotic medication. What do we currently know about the safety and long-term effects of these drugs in kids?

I've often said children are not just little adults. They're different. And what might work in an adult, even if you say, "Well, we'll reduce the dosage," that sometimes doesn't always correlate. I don't want to practice medicine without a license. But, nonetheless, we know that to be a fact. What do we currently know about the safety and long-term effects on these kids, and what areas require further research and study?

Dr. INSEL. Well, in fact, there is a real concern, because the use of antipsychotics in children has gone up markedly over the last decade. What we do know is that children are actually more sensitive to the side effects, particularly the metabolic side effects. And that's a real concern because, often, these drugs are used long term.

So there's an issue. There's a real issue about practice and about improving the quality of practice in this regard. And I should say that some of this may be related to a reluctance for many clinicians to use antidepressants, which are probably somewhat safer. But there are concerns about suicide and actually violent behavior.

The curious thing to know here is if you look at the other side of this—we're not talking about young children, but when we talk about adolescents and the example that Senator Alexander used about the 15- or 16-year-old who was beginning to hear voices and who's going down this path of psychosis, what tends to happen most often is not that people are getting over-treated with medications but that they're not getting diagnosed and treated at all.

Specifically, with respect to our concerns about violent behavior, we know that treatment reduces that. The most important thing you can do if you want to prevent new events like this, the ones that we've often talked about over the last 5 or 6 years, is to ensure that people who are on this path to becoming psychotic and paranoid and grandiose and perhaps dangerous are treated.

The risk of violence is fifteenfold higher prior to treatment than it is after, and treatment often does involve antipsychotic medica-

tion. It's not the whole treatment, but it is a part of making sure that people who are developing a psychotic illness are actually not going to become a risk to themselves or others.

The CHAIRMAN. We'll hear testimony later from the next panel about approaches such as mind-body connections and things like that in terms of perhaps—especially as we get into prevention and we start recognizing in young children in school and other places certain types of behavior that maybe early interventions with family counseling and therapy might be more successful than just giving them an antipsychotic drug. Do you have any comments on that?

Dr. INSEL. There are only a few reasons to use an antipsychotic drug in a young child. Probably the most common and the one that is approved by the FDA is in autism, where there are forms of irritability and what you might call temper tantrums in which children will hurt themselves or hurt somebody else, often very young children. And in that case, the FDA has approved the use of two different antipsychotic drugs to help control that kind of behavior.

But for the most part, the medications that are approved for use in children and the ones that seem to show the greatest efficacy are in other classes, particularly for children who have, for instance, attention deficit hyperactivity disorder, where the psycho-stimulants have been shown over and over again over the last four decades to be not only of high efficacy but high safety as well. And we know from long-term studies that that's helpful.

So I wouldn't say that in any of these cases medicine is the whole answer, but it's often helpful as part of the answer. There are lots of other kinds of interventions that are being developed and some that still need to be developed that may be far more effective beyond medication. So this is just a part of the story.

The CHAIRMAN. Thank you very much, Dr. Insel. My time is up. Ms. Hyde, do you have a short comment?

Ms. HYDE. I was just going to say that from a population-based point of view for young children, there are interventions, not for people who have been identified with an issue, but in classrooms; for example, a program that we support called The Good Behavior Game, which has shown a fairly remarkable ability to help teachers manage behaviors in classrooms, that does have long-term impacts.

The CHAIRMAN. Thank you.

Senator Alexander.

Senator ALEXANDER. Thanks, Mr. Chairman.

Ms. Hyde, it looks like, just looking at Tennessee, that maybe a quarter to a third of the funds that are available for mental health and substance abuse through the State government are Federal dollars. Does that sound about right for the country? Is that your experience? Most of it goes through two big block grants, or one big one and one smaller one. Is that about right?

Ms. HYDE. Sort of a rule of thumb is somewhere around a quarter of the funding for the Nation—I don't know about Tennessee, particularly—but is——

Senator ALEXANDER. Well, for the Nation, that sounds about right.

Ms. HYDE. It sounds about right if you take the Medicaid dollars. Each State has a different match, of course, so that changes how much is State dollars and how much not. About half the dollars that go for behavioral health of the country as a whole are public dollars, Federal and State.

Senator ALEXANDER. Do you regularly consult with the State mental health directors about your two block grants and how they're administered and how the money is—how you might improve the process of applying for that money and make it easier for them to help the people who need help?

Ms. HYDE. Absolutely, Senator. We put out a block grant application. It's now a uniform application that makes it easier for States to apply for the funding. We go through a public process as well as an informal process of asking for input from the States and the two State associations that represent State agencies in that process.

Senator ALEXANDER. I have heard that the statutory deadline for the two block grants is in the fall, September and October, but that you've indicated that you've moved that up to the spring, and that's causing some States to have concern about being able to get ready for the applications because of the legislative sessions, and that there's some confusion about how much information is requested, and that if as much is requested as it appears to be that it might be burdensome. Have you heard that from State directors? And, if so, what are you doing about that?

Ms. HYDE. Thank you, Senator. Interestingly enough, we actually changed that date initially in consultation with some States. What we were trying to do is push up the date so that they could do their planning during their legislative process, so that as their legislature decided match moneys, or what we call maintenance of effort moneys, it could be tied to the block grant dollars. Since the application is not yet out, we probably will change that date before the final application comes out.

Senator ALEXANDER. Could I encourage you to take a look at that and make sure that it's not a burden on the States?

Ms. HYDE. Absolutely.

Senator ALEXANDER. You mentioned the mental health parity letter that came out earlier this month. Did the mental health parity law apply to Medicaid by its terms, or does it apply to Medicaid by the terms of the new healthcare law? Or is the letter something that expands the application of mental health parity to Medicaid?

Ms. HYDE. The letter just explains and provides guidance to States about how MHPAEA, the Federal law about parity, applies to certain portions of the Medicaid program. So Medicaid benchmark plans and benchmark equivalent plans, as they're called, or alternative plans are subject to MHPAEA whereas the basic underlying Medicaid program in the States are subject to other laws.

Senator ALEXANDER. So it shouldn't be any surprise to Governors who are evaluating the cost of Medicaid expansion that the mental health parity law applies to Medicaid.

Ms. HYDE. Senator, I don't know if it's a surprise. It, in fact, applies to certain portions of it. So part of the reason for the letter was to try to describe the differences about where it applies and where it might not.

Senator ALEXANDER. That's helpful. I've heard from a number of Governors, who haven't made a decision about Medicaid expansion, that it's hard for them to make that decision without knowing the added cost of it to the States, as Medicaid has grown as a part of State budgets, for example, in our State, from 8 percent when I was Governor to 26 percent today. So did you detail in your letter what the added cost to the Federal Government or States would be as a result of the application of mental health parity to Medicaid?

Ms. HYDE. No. The letter was not about cost, although, as Congress went through the process of passing the MHPAEA, or the Mental Health Parity and Addictions Equity Act, there was significant discussion about cost, and all the studies that have occurred have indicated that the cost is negligible. In fact, MHPAEA does allow a plan to request an exemption if their costs go over a certain amount. So that is part of the MHPAEA law.

Senator ALEXANDER. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Alexander.

Now, as you know, it has been a tradition or rule of this committee that Senators are recognized in order of appearance, and I have here Senator Murray and then Senator Enzi—we'll go back and forth—and Senator Baldwin, Franken, Murphy, Sanders, Mikulski, Whitehouse, and Warren.

So I would now recognize Senator Murray.

## STATEMENT OF SENATOR MURRAY

Senator MURRAY. Thank you very much, Mr. Chairman, for holding this really important hearing. It is, I think, especially important to note that, obviously, the issue of Newtown focused everybody on it. But this is an issue that a lot of us have been working on for a very long time, yourself included, and I think it's a great time to refocus. I think it's really important that it's your first hearing, and I appreciate that.

Senator Alexander, I welcome you to the new Ranking Member position and look forward to working with you and all of our new members. It's great to have you on this committee. There's a lot of great talent here.

Mr. Chairman, I think that we'll really be able to do some good things with this committee. So thank you very much, and to both of our witnesses as well.

I did want to go back. Senator Harkin has mentioned it several times. But in the President's recently released gun violence package, he issued three parity provisions, one clarifying parity for Medicaid-managed care plans, one saying that a parity provision would be included in the final essential health benefits rule, and one that committed to issuing the final rule on the Mental Health Parity and Addiction Equity Act which you've mentioned.

But it didn't make clear, and you haven't yet made clear, when we're going to actually see that. If these plans are supposed to be ready to go into exchange starting in October, it's really essential that we see a final rule on this before April. So let me go back to the question that Senator Harkin asked again and ask you to be specific about a date that we will see this final rule in place.

Ms. HYDE. Thank you, Senator Murray. I think the President's proposals indicated that the essential health benefits rule would be out next month. We are working on the MHPAEA final reg, and it will go through the regulatory process and is in that process now. I can't give you a specific final date, but we are on it.

Senator MURRAY. Will we see it by April?

Ms. HYDE. I can't tell you precisely what the date is, but we are on it now.

Senator MURRAY. Well, it is really essential because our States are working on these exchanges and they need that clarity to move forward. So I can't urge you strongly enough that that date is critical.

Mr. Chairman, one of the issues I have focused a lot on in terms of mental health, obviously, is our military families. And I just continue to believe we have to do everything we can for our veterans and our service members as they transition, especially during difficult periods of redeployment and returning home, transitioning back into the civilian world.

But the focus also has to be on the families of these veterans, and I'm certain that is the same throughout all of mental health, whether you're talking about military or a number of the other topics you've been talking about. The Mental Health Access Act that we wrote included provisions to expand some of the VA mental health services to family members. Can you tell me how you've been progressing in implementing the military families initiative?

Ms. HYDE. Yes, Senator. You may recall that the President issued an Executive order in the fall asking HHS and DOD and VA to collectively work on improving the mental health access for service members and veterans. We're actively working on that together, the three departments.

Part of the way we're trying to get at the whole family and the whole needs of the individual is looking at partnerships between community health centers, community mental health centers, and VA organizations. There are times when family members cannot access Veterans Administration, but they can access that other mental health center down the road, or vice versa.

So we have been trying to look at pilots. The Executive order called for us to work on pilots. We're doing that. And we've also been meeting with stakeholder groups, and some of those stakeholder groups have been families of veterans, service organizations, and others giving us their input about the best way we can provide that. We have a report due to the President by the end of February, so we're actively engaged in that process.

Senator MURRAY. I'll really look forward to seeing that. And Senator Sanders is taking over the Veterans Committee, and he has a strong interest in community health centers as well. So I know we'll continue to be able to push on that. But I think it's really important that we focus on that for our military families.

Dr. Insel, thank you so much for talking about the importance of reminding all of us that mental health doesn't mean that someone is violent. I think that's really important to remember as we go through this. And, of course, we do need to focus on that population that has the potential to become violent, particularly at the younger ages.

So, Mr. Chairman, I think that's why this hearing is so essential, and I really appreciate and look forward to hearing the testimony of the rest of the panels. Thank you.

The CHAIRMAN. Senator Enzi.

STATEMENT OF SENATOR ENZI

Senator ENZI. Thank you, Mr. Chairman, and I want to congratulate Senator Alexander, who gave up a leadership position on our side in order to be the Ranking Member on this committee. It shows his dedication to health and education and workplace safety and training and pensions, and I know that he'll do an outstanding job. And I appreciate you holding this hearing on mental health as the initial one.

My first question is for Administrator Hyde. I want to know more about the coordination and collaboration of agencies at the Federal, State, and local levels. Within your appropriate role as a Federal agency, what needs to be done to better enhance that coordination and collaboration of agencies at the Federal, State, and local levels?

Ms. HYDE. Thank you for that question, Senator. We've actually been trying very hard to recognize the relationship between States and local communities, because the State often will create laws, rules, regs that, of course, the community has to respond to. So when we provide grants, for example, to our communities, we're trying to say, "How does this relate to your State's plan and direction?"

Likewise, when we're providing grants to our States, we're trying to ask, "How are you bringing your communities into that process?" So we are, by our grant making, trying to bring them together. Through our community block grant application process, we're also asking how these things relate to what's going on at the community level.

And then we have been providing significant technical assistance, because there's a lot of change going on in the health delivery system to both our States and to our provider agencies which provide the basic community infrastructure. We also have county-based programs that we do a significant amount of work with. So we're trying to look at those relationships.

I, personally, have had the opportunity to work at all of these levels, city level, county level, State level, and now the Federal level. And sometimes what you feel is where you sit, but I understand probably only too well how much those relationships matter. So we are working on them significantly.

Senator ENZI. Thank you, and I look forward to any suggestions you might have.

Dr. Insel, what do we need to do to close the gap between research and real-world practice to ensure that evidence-based treatments are available in the community service settings?

Dr. INSEL. Thank you. It's a question that we discuss a lot at NIH, not just within the mental health arena, but across all of the diseases for which we're responsible for providing better science. The typical response to your question or the typical assumption behind it is that there's this sort of 17-year gap between a discovery

and implementation. What we used to talk a lot about was how do you move from research to practice.

Interestingly, I'd say in the last 2 or 3 years, there's been a transformation in how we talk about this. And, increasingly, we're beginning to say,

> "You know, how do we move from practice to research? How do we make sure that we have developed not just healthcare systems, but learning healthcare systems, healthcare systems that are involved in the research process itself?"

At NIH, we've created several efforts to do that involving millions of patients through large healthcare systems, like Kaiser and many others, in which we are doing research or we're doing actual practical trials in these very large groups at a much reduced cost. But the advantage of that is that you're making discoveries in the place where they will be implemented rather than doing it, for instance, in an academic center where there may still be a gap to getting it to the community.

The other piece of that that's so important—and it's actually part of a new institute that was formed at NIH—NCATS is actually bringing in the community at the get-go and making sure that the kinds of questions that are being asked by science are going to give you the kinds of answers that people in the community are looking for.

Senator ENZI. Any reinvention is always appreciated. This next question is for both of you. What type of oversight or financial controls are in place to ensure that Federal funding is being used effectively to prevent and treat substance abuse use disorders and mental illnesses? What needs to be done? What changes are needed?

Ms. HYDE. I'll start with that question, Senator. For almost all of our programs, we do an evaluation of the program to see what kind of outcomes we're getting and what the results are, and we try to use those evaluation results in how we do the next round of program activities. We also provide some of the largest amounts of surveillance data in the area of behavioral health, both substance abuse and mental health, and we're trying increasingly to use that data to help us understand where we need to go.

We're working on something called the National Quality Framework, National Behavioral Health Quality Framework, which is a second step from the National Quality Strategy that was called for in the Affordable Care Act. And in that we will be laying out the framework for quality direction for behavioral health as a whole at different levels.

We also, obviously, collect information and data from each of our grantees, and we are trying to make some improvements in that by streamlining our data collection systems. We have multiple systems now that we're trying to put into one that we hope is more effective and easier for States and communities to report into.

There's a number of activities that we are going through around accountability and evaluation. And we work very well with NIMH, NIDA, and NIAAA on the way that their services—or the research that they provide and how we can bring it into our practices as well.

Senator ENZI. My apologies. I've used up more than my time. If Dr. Insel would answer that in writing—and I'll also be adding a question about duplicative programs between all agencies.

Dr. INSEL. I look forward to it. Thank you.

The CHAIRMAN. Thank you, Senator Enzi.

And now Senator Baldwin. Welcome to the committee.

STATEMENT OF SENATOR BALDWIN

Senator BALDWIN. Thank you, Mr. Chairman. I am really delighted to join the committee and very pleased that the first hearing in this committee this session is devoted to this incredibly important topic.

Ensuring access to quality and affordable healthcare has been and will always continue to be a very high priority of mine. And when I say healthcare, I don't distinguish between physical health and mental health, because, to me, they should be viewed as one and the same. The Mental Health Parity Act and the Affordable Care Act both take important steps to make this vision a reality. And together those two laws will both expand healthcare insurance coverage to millions of previously uninsured Americans and increase access to mental healthcare for millions more who have health insurance coverage.

My first question relates to increased access to insurance coverage. As we speak, Governors across this country, including in my home State of Wisconsin, are grappling with the decision of whether to expand Medicaid coverage under the Affordable Care Act. In my home State, around 200,000 Wisconsinites could gain Medicaid coverage through the Affordable Care Act Medicaid expansion should our Governor make that decision.

Ms. Hyde, I really appreciate the fact that in your testimony you pointed out that Medicaid is currently the No. 1 payer for mental health services in the United States. We know that many vulnerable Americans do not currently qualify for Medicaid coverage.

In your opinion, how might States that are grappling with this decision or States that are choosing to expand Medicaid coverage under the Affordable Care Act improve mental health outcomes for their most vulnerable citizens? Or, perhaps alternatively, what variation might you expect to see between States that choose to expand Medicaid and those that don't with regard to treatment of mental illness?

Ms. HYDE. Thank you, Senator, and welcome.

Senator BALDWIN. Thank you.

Ms. HYDE. We are very optimistic that as States go through their processes that they will come to the decisions to provide the opportunities for coverage for their citizens. And in that process, obviously, each State looks at its own Medicaid program. However, the letter that we just recently put out was an attempt to try to help States understand how they should be looking at mental health and substance abuse treatment within those contexts.

There are certainly services that we know can work. We are working very closely with the Medicaid agency, CMS, our partner agency, in putting out informational bulletins on how States can use their Medicaid program to increase access and to do better for behavioral health. We are working with them to do that. We also,

frankly, are working on the enrollment and eligibility process with the department as a whole, because we know that people with behavioral health needs typically, even after fuller coverage, have a harder time staying covered.

We are doing both, trying to get access through enrollment and eligibility, trying to get access through the type of service or the array of services that might be provided, and just trying to provide information to help the States understand what's the most effective way to provide these services and the kinds of services that are most cost effective and most effective for treatment.

Senator BALDWIN. Thank you. One of the ways that we've already seen expansion of access to care—and you were talking in your testimony today about the barriers being cost and access, ET cetera—is the provision in the Affordable Care Act that allows young people to stay on their parents' health insurance until they're 26, something I am particularly proud of because I worked very hard on that in the House Energy and Commerce Committee, and we're pleased to see it in the final act.

I'm wondering, especially given that your testimony talks a lot about the age of onset of many profound mental illnesses being between 16 and 25, whether you're already observing the positive impact of that increased level of insuredness for that age population, that age cohort.

Ms. HYDE. Well, we certainly know that both the provision to allow young people to stay on their parents' insurance and also the provision to prohibit exclusion from preexisting conditions both help young people with mental health and substance abuse disorders stay on and keep insurance, or be able to get access to insurance when they may not have access to it otherwise. Millions of young people are covered through that process already, and we know—I don't have a specific number, but we know that those young people who have these disorders are part of that group.

The CHAIRMAN. Thank you, Senator Baldwin.

Senator Murkowski.

## STATEMENT OF SENATOR MURKOWSKI

Senator MURKOWSKI. Thank you, Mr. Chairman, and I join the rest of my colleagues in thanking you for calling this hearing on an incredibly important subject. I'm told by my staff that we haven't had a hearing in the HELP Committee on mental health issues since 2007, which is way past time. So thank you for your attention to this.

I have been focused on the issue of suicide for years now and, particularly, youth suicide in this country. In my State, we have some very troubling statistics, but the one that I find most disturbing are our statistics when it comes to youth suicide. In the country, the rate of suicide was 11.5 suicides per 100,000 people. In Alaska, we're looking at a suicide rate of exactly double that, 21.8 suicides per 100,000 people.

Even worse are our statistics as they relate to our Alaska Native young men. Those between the ages of 15 and 24 have the highest suicide rate of any demographic in the entire country at a rate of 141.6 suicides per 100,000 people per year, and this was between 2000 and 2009. For us, it's staggering, and it's something that I

just find so troubling, that in everything that we do, we cannot seem to be making inroads here. So I have long been focused on it.

I just reintroduced, along with Senator Reed, legislation that will help to address the youth suicide, and this is the Garrett Lee Smith Memorial reauthorization. We've got a good group of cosponsors. What we're seeking to do is to provide a focus on youth suicide in several different areas; to provide for prevention programs; and also, in addition to providing these grants to States and tribal organizations, to provide them to colleges and universities as well.

The question that I have for you as director here is how we can do more within our colleges and within our universities to provide for identification, early treatment, early intervention and the treatment services that might make a difference with our young people in our universities. We see these documented mental health needs. I'm concerned that we don't have sufficient flexibility within the programs that currently exist to help address this need. Can you speak to your observations and what we could be doing better to address those in our colleges and universities?

Ms. HYDE. Senator, thank you for the question. As you know, the surgeon general along with a very strong public-private partnership last September put out the surgeon general's National Strategy for Suicide Prevention. In that strategy, there were several high priority things identified. I don't have the time nor the memory to go through all of them at this moment. But there were some very key things, like identifying—even as we've been talking about it in this youth age group having—raising awareness.

Some people know what to look for—having people be able to get help better, engaging an aftercare, to use that term, so when people do have risk of suicide or they make a suicide attempt, then followup to make sure that there's adequate followup, because we know that's a high-risk time, providing clinical standards so that clinicians know how to do the screening, and that includes campus-based programs. We're proud to administer the Garrett Lee Smith program, and we are seeing great results in terms of raising that awareness.

Part of the President's proposals also include the idea of a mental health first-aid approach in trying to get people more aware, especially focused on youth, of what to look for, how to get help, how to know someone needs help, and how to help them get that.

Senator MURKOWSKI. Well, I would hope that we could work with you on this. Again, this is a key, key issue for us.

Dr. Insel, let me ask you a quick question. It has been noted by my colleague, Senator Baldwin, that the identification of mental illness in terms of recognizing what we're dealing with—the onset is as early as age 14, and that the early identification can really help with improving outcomes. Yet most of our primary care providers that are out there are probably not adequately prepared to identify mental illness at its earliest stages or provide for that appropriate care.

What can be done? What is the Administration doing to support primary care, to improve these training opportunities so that we can do that early intervention, that early identification?

Dr. INSEL. That's such an important question, Senator, because as we talked about earlier in the hearing, the lesson that we've learned over and over again in biomedical research is that early detection and early intervention give you the best outcomes. So we do need to do better at this. And it's challenging in this sphere because we do not have biomarkers the way we do for heart disease or cancer or many other diseases, where we can take a blood test and know who has what or who's on the high-risk path to develop something.

NIMH is invested very heavily in developing just those kinds of tests, whether they're cognitive or biological, to know who's in a high-risk state. But that's a long-term plan, and I don't think we can wait to make sure that there's better awareness and better community support. So one of the things that you heard—and Pam has already spoken to this—is Project Aware, which was announced last week by the President, which is an attempt to go out and increase awareness in schools, in primary care, and in communities about the challenge that we face, the need to be able to detect the earliest signs, at the same time recognizing that there are a lot of teenagers who are struggling, and we don't want to label every one of them as having an illness.

So you need to be sensitive to getting better and better, more precise measures about who really is at risk and knowing who to intervene with. So we've got to find the right balance here, and, hopefully, science will bring us some better tools for that.

Senator MURKOWSKI. My time has expired. Mr. Chairman, I apologize for having gone over. Thank you.

The CHAIRMAN. Thank you, Senator Murkowski.

And now Senator Franken.

## STATEMENT OF SENATOR FRANKEN

Senator FRANKEN. Thank you, Mr. Chairman. Like all the members of this committee, we thank you for calling this hearing.

I want to welcome Senator Alexander as our new Ranking Member. I look forward to working with you.

And I want to thank Senator Enzi for his work as the former Ranking Member.

Like everyone on this committee, I was devastated by the tragedy in Newtown. And in the wake of this tragedy, there's been a new focus on mental health issues, which I've been working on for a long time. Paul Wellstone held the seat that I hold, and I, too, share the sense of urgency about the rules on Wellstone-Domenici being finalized.

While I'm glad we're focusing on mental health, I think it's important not to stigmatize people with mental health issues or generalize about the connection between mental illness and violent behavior. And I want to thank both of you for making that very clear. As Ms. Hyde said in her written testimony, most people who are violent do not have a mental disorder, and most people with a mental disorder are not violent.

And, Dr. Insel, you said essentially exactly the same thing.

We should make sure that everyone has access to mental and behavioral health services that they need, because it will make our communities and families and them healthier and happier. But,

again, I think it's absolutely vital that we not stigmatize mental illness in the process. I think that would not only be counterproductive but counterfactual.

In the next week, I'm going to be introducing two bills that will expand access to mental health services. I'll be introducing the Justice and Mental Health Collaboration Act. It's really a reauthorization and an improvement, I hope, upon MIOTCRA, and this is about when people with mental health issues encounter the criminal justice system. I have seven Republican sponsors on that, including Senator Hatch on this committee.

I'm also going to be introducing the Mental Health in Schools Act, which dovetails with Project Aware. And this is where, Dr. Insel, your testimony, and your testimony, too, Ms. Hyde, is so important. And it's about schools identifying and treating—giving access to treatment to kids. The statistics you mentioned—only one in five of children who have a mental health issue get seen or treated.

My legislation will allow schools to collaborate with mental health providers, law enforcement, and other community-based organizations to provide expanded access to mental healthcare for their students. It will also support schools in training staff and volunteers to spot warning signs in kids and to refer them to the appropriate services. And I'm glad that Project Aware has the same kind of focus.

I want to ask about the evidence in terms of—with the caveat that both of you made about not stigmatizing mental illness and associating it with violence. If mental health issues go untreated, does that increase the chance that someone in a subset, a certain subset of a type of mental illness, will become more violent, or will there be a higher chance of that?

Dr. Insel.

Dr. INSEL. Senator Franken, within that narrow band of the people we're talking about, which is a small, small segment of the population of people with a mental illness, those, for instance, who have what we call first episode psychosis—we know that the duration of untreated psychosis is related, in fact, to the risk for having a violent act. That's been studied quite carefully, and there's a real correlation there. So closing that gap is one of the things we can do to increase safety.

Senator FRANKEN. So, in a sense, Newtown did prompt this. In that very narrow—and that was one of a number of horrific occurrences where I think that no one would question that in Tucson, Newtown, we're talking about someone who's deranged. And had that person been diagnosed, say, in school and had been able to get some kind of treatment—there is some kind of connection between making sure that we're identifying and treating children early on with the tragedy that brought us here.

Dr. INSEL. I'm not going to speculate on those individual cases because I haven't seen them. But the data, the published data, are quite clear that the difference between severely violent acts like homicide between those who are untreated and those who are treated is fifteenfold. You drop the risk fifteenfold with treatment. So it's vital, absolutely vital, that we detect earlier and intervene earlier with something that's effective.

Senator FRANKEN. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Franken.

Let's see. Senator Murphy has left right now.

Senator Sanders.

Senator SANDERS. I think Senator Mikulski had an engagement, and she wanted to ask just one question.

The CHAIRMAN. Absolutely.

## STATEMENT OF SENATOR MIKULSKI

Senator MIKULSKI. Thank you very much, Senator Sanders. I have a meeting with Senator Shelby to help organize the Appropriations Committee. And that will take me to the questions for Dr. Insel and Dr. Hyde.

I think what we're hearing today is that effective intervention, whether it's autism or chronic schizophrenia—it's research, it's treatment, and the workforce to make both happen. My question to each one of you—if we could just take the issue of research and then perhaps of workforce, but particularly research.

Dr. Insel, what will be the consequences of sequester on the work of the National Institutes, your National Institute of Mental Health? You've talked about this outstanding work that you're doing. What will happen?

Dr. INSEL. At this point, what we're looking at is about a 6.4 percent reduction in the 2013 budget, and, of course, that will come, if it happens, sometime in March or April.

Senator MIKULSKI. But what are the consequences?

Dr. INSEL. Well, there'll be certain studies that we would like to do that are not going to be done at that budget. And one of the major projects that we're involved with is actually highly relevant to this discussion today, which has to do with how do we ensure that we have the kinds of predictors for early psychosis. We have a large national study in what we call the prodrome that we would like to scale up, and that's probably not going to be done if we don't have the funds to expand what we're currently doing.

Senator MIKULSKI. So there would be others along those lines.

Now, Ms. Hyde, when one looks at the operation under your organization, what would be the consequence—and you can't have mental health without mental health practitioners, which usually goes to training grants, educational grants, actual workforce needs, particularly, as you know, at the State and local government. Would sequester have any impact on workforce issues, and what would they be?

Ms. HYDE. Senator, I think it goes without saying that we all hope that sequester, which was never really intended to happen, doesn't happen. But SAMHSA does a lot of technical assistance and training, and we provide a lot of materials and practice improvement for the workforce. And to the extent that we don't have the same number of resources to do that, then less of that will certainly be able to be done and less of the grants that we put out as well.

Senator MIKULSKI. Will it have a direct impact on training?

Ms. HYDE. Senator, it very well could. Again, we have a fairly significant portfolio in providing what I call workplace or practice

improvement efforts. And that, again, includes training, technical assistance, materials, just access to resources. So those all take resources to do, and to the extent that we have the resources, we do it, and if we don't, then we do less of it.

Senator MIKULSKI. Well, I get the picture, and we will be coming back for more detailed questions on that. But I think this looming threat is severe, and I'm sure it has a tremendous impact on morale.

But Senator Sanders yielded his time to me. And, Senator Sanders, I appreciate it. I know you're keenly interested in that area as well.

Let me just say one word. The reason I asked about the training—I went to graduate school on an NIH grant. When this 1963 bill was signed for mental health community centers, I was a social worker working as a child abuse worker. Because of that, at age 27, I was able to go to graduate school and get a master's in social work, and I was supposed to specialize in community mental health.

Now, many might not think I have a therapeutic personality. But I did learn a lot, and I learned that these scholarships and so on make a difference in lives, and the consequences of well-trained people and what they then produce in our society I know is important.

Dr. INSEL. And we hope your training is successful in the appropriations process as well. So thank you for that.

Senator MIKULSKI. I intend to be very agitated about a lot of things.

[Laughter.]

The CHAIRMAN. Senator Sanders.

## STATEMENT OF SENATOR SANDERS

Senator SANDERS. Thank you very much, Mr. Chairman. Newtown and other events have highlighted the importance of this issue, and I very much appreciate you holding this hearing.

I'm going to approach the issue in a little bit different way, Mr. Chairman, than some of our colleagues. The United States of America is the only country in the industrialized world that does not have a national healthcare system. In my view, in the midst of major healthcare crises in this country, including 50 million people today without any health insurance—hopefully, that number will be significantly reduced under the ACA—the reality is that when you don't have a system, you're not prioritizing.

So what that means is not only are we not paying adequate attention to mental health, in general, but the disparities based on income and where you live are also enormous. Senator Murkowski mentioned the problems in rural Alaska with Native Americans. What I can tell you—and I want you to deal with this for a moment. If I'm making a half a million dollars a year, and I'm living in New York City, and my kid has problems, the likelihood is I'm going to be able to get reasonably good mental health treatment for that kid. That's the likelihood for my kid.

On the other hand, if I live in rural Vermont, and I'm making $25,000 a year, you know what? I'm going to have a very difficult time accessing the mental healthcare that my kids need. And that's

true, I suspect, in Tennessee, and I suspect that it's true all over America. The reality is, right now, that we have a primary healthcare system which is a disaster, that whether it is physical illness or—you made the point that we do well with mental health when people can access the system when they need it.

In my office, I can tell you we get calls in Vermont where family members say, "I have—my kid, my husband—serious problems. I can't find mental health treatment now." So let me ask you a simple question. If our goal is to make sure that mental healthcare is available to all people who need it, how many thousands and thousands of mental health practitioners does this country need, and how do we get them?

Dr. Insel, why don't we start with you?

Dr. INSEL. I'm going to turn to my colleague who is just completing a workforce estimate, and so she's actually looked very carefully at this issue.

Senator SANDERS. Ms. Hyde, how many thousands of mental health practitioners do we need?

Ms. HYDE. We don't have good studies that say how many we need. We have lots of data that tell us what we don't have. And we have lots of data that give us comparisons between certain areas and certain types of practitioners. We are just completing a report for Congress on that. It'll be ready soon.

Senator SANDERS. But before we even get to the report—and we need good data—tell me, is it fair to say that if I am a low-income person living in rural America or urban America, today I am going to have a very difficult time finding mental healthcare for my loved ones?

Ms. HYDE. Senator, I was actually going to go right there, so thank you for the question. It's not even so much—although, clearly, in certain areas of practitioners, we don't have enough. But it's also the distribution. I come from New Mexico, so we have major rural areas in New Mexico, and there are counties in New Mexico that don't have any behavioral health practitioners, none, zero. Something like 75 percent of the psychiatrists are in what we call the Rio Grande corridor.

Senator SANDERS. Which, let me guess, is probably—not knowing anything about—a wealthy——

Ms. HYDE. It's Albuquerque and Santa Fe, yes.

Senator SANDERS [continuing]. A wealthy area.

Ms. HYDE. Well, it's more urban, certainly, yes, and where the universities are.

Senator SANDERS. We don't have a whole lot of time. So my question is if I am a working class person, if I am unemployed in this country, is it a fair statement to say, especially if I'm living in rural America, that it would be very, very hard for me to access affordable mental healthcare in a timely manner? Is that a fair statement?

Ms. HYDE. I think it is fair to say that rural areas have a more difficult time. There are clearly programs like community mental health centers, like community health centers, that have been explicitly set up for that.

Senator SANDERS. Well, I worked very hard—let me just interrupt. I'm sorry. I apologize. We don't have a lot of time.

Ms. HYDE. That's all right.

Senator SANDERS. I worked very hard to double the funding of community health centers and triple the funding for the National Health Service Corps. I think we made progress. Would you agree that we have a long, long way to go to expand even beyond where we have gone in recent years?

Ms. HYDE. I would agree that we need more practitioners, absolutely.

Dr. INSEL. And I would add to that that it's not only across the board, but there are particular areas of need that need attention. One of them is in children, and we've been talking a lot about youth needs. Child psychiatry is a way underemployed——

Senator SANDERS. Absolutely.

Dr. INSEL [continuing]. And child psychology is incredibly important to build the workforce.

Senator SANDERS. All right. Let me just conclude. I think it's a class issue, too, Mr. Chairman. I think to some degree psychiatry is something that is accessible for urban, upper income folks. It is not accessible for low-income rural folks. So I think the point that Ms. Hyde made is an important one. We have to look at geography, and we have to make sure that mental health is available to all people, regardless of their income, all over this country.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Sanders. I might just add that since I focus so much on prevention and early intervention right now, school psychologists—the national average is 1,500 to 1. The recommended ratio—I don't know recommended by whom—is 700 to 800 students per psychologist. So we need to double that if we're even going to meet the recommended level for kids in school.

Senator Warren, welcome to the committee.

## STATEMENT OF SENATOR WARREN

Senator WARREN. Thank you very much, Mr. Chairman. It's good to be here. I want to apologize for coming in late. I have the best possible excuse. I was introducing my senior Senator, Senator Kerry, to the Senate Foreign Relations Committee. And I believe that will not be a recurring event.

The CHAIRMAN. Is that your way of saying soon you will be the senior Senator from Massachusetts?

[Laughter.]

Senator WARREN. Yes, sir, it is. So I thank you.

I would like to start with my questions in the same place that Senator Enzi started. I have a very similar interest in the questions about research around evidence-based medicine, around accountability, around our funding for research.

What I'd like to do is just start with you, Dr. Insel, if you would, and I'll ask you to do two things for us. The first is just paint us a little bit of a picture about what we can do with research in the mental health field. If we get some good research, what can we learn that we don't know? And would you talk just a little bit about what funding levels are doing to research?

Dr. INSEL. Thank you for that question. I don't usually get an opportunity to talk about this, and I promise I'll do it very quickly. But you're asking the question at a critical moment in time. We are

really, in the case of understanding mental illness, where we were in some ways for studying cancer 20 or 30 years ago. We're just on the cusp of a revolution, and it's because we have these extraordinary tools now.

For the first time, we can approach problems of the mind through studying the brain, and that gives us a kind of precision that we've never even imagined we could have. The reason that's so important is because for behavioral problems, whether they're in Parkinson's Disease or Alzheimer's Disease or Huntington's Disease, the behavioral symptoms are a very late event. Those are the heart attacks. And it's the same thing, we believe, for the psychosis and schizophrenia.

We define these as behavioral disorders. But, in fact, they're brain disorders, and the brain changes are probably occurring years earlier. And if we want to detect and intervene earlier, we're going to have to be able to develop ways to get at that, to understand them as brain disorders in the same way that we've done now in many other areas of medicine.

I think where the science is taking us is toward the biomarkers. It's toward the fundamental biology. We have not been there before. We've had a very simplistic approach to this. It is far more complicated. The good news is we've got far better tools to be able to unpack this.

Your question was about the funding. It's a challenge. There are lots of questions, lots of things we'd like to answer. I'd have to say that for NIMH, the shift has largely been to move much of our funding to people who actually 10 years ago were studying cancer and heart disease who are now joining us because they feel that autism and schizophrenia are the new frontiers, and these are the places where you're going to make the big breakthroughs.

It's always frustrating because there's, of course, never enough funding to support all of the best ideas that come in. We try to support about 20 percent of them. So that one in five grants gets funded. I hope that I'm smart enough to pick the best 20 percent. I'm afraid I'm not, and I think if I could do 30 percent, I'd probably have a much better hit rate. It's just hard to know often. So that's always the challenge. You never have the funding you want to do all the science, some of which is just spectacular, that's sitting there in front of you.

Senator WARREN. Can I ask you just to expand on that in one more dimension, and that is—you described it as your hit rate. If you really hit on some of these studies on Alzheimer's, on autism, can you just speak briefly about what the financial impact will be on the country?

Dr. INSEL. Well, we know that in the case of Alzheimer's that if we can just forestall the dementia by a matter of 1 year or 2 years, which is certainly, I think, within our grasp as we've gotten a better understanding of how to predict and are now looking at ways to intervene, we're talking about billions of dollars that would not have to be spent, which are now going into the care of people with dementia.

It really comes down to a question of do you want to invest early, or do you want to pay later, because you don't know enough and you're not doing this in a way that's efficient. And, unfortunately,

I think we've tended to decide that we'll pay later, often at a very large premium, instead of making the early investments in Alzheimer's, autism, schizophrenia to make sure that we come up with better solutions.

Senator WARREN. Thank you very much.

Ms. Hyde, my time has expired. But if you had a quick comment you'd like to add, I'd be grateful.

Ms. HYDE. The quick comment here is you know, of course, that these disorders have profound impacts on our justice systems, on our school systems, on our public welfare systems, our child welfare systems. There's profound dollars that are being spent there because we are not intervening early, because we are not providing the kind of supports to the young people and their families.

Senator WARREN. Thank you very much.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Warren.

Senator Bennet.

## STATEMENT OF SENATOR BENNET

Senator BENNET. Thank you, Mr. Chairman. I was unfortunately on the floor with my senior Senator—there's nothing unfortunate about that—on an issue of great importance to Colorado, so I missed the testimony. I think I'll refrain from asking my questions now. I'll submit something for the record if that's OK with you, and I know there's a second panel.

But I want to thank you very much for holding this hearing. And I'd like to join Senator Franken in saying how delighted I am to see our Ranking Member, Senator Alexander, here and thank Senator Enzi also for his work as the former Ranking Member of the committee, and, finally, to welcome our new colleagues to the committee. It's wonderful to see you here.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Bennet.

I thank our first panel. Thank you, Dr. Insel, and thank you, Ms. Hyde, for being here.

Now we'll call our second panel, Dr. Michael Hogan, Dr. Robert Vero, Mr. George DelGrosso, and Mr. Larry Fricks.

On our next panel, first, I'll introduce Michael Hogan. Dr. Hogan is the former commissioner of the New York State Office of Mental Health and chairman of the President's New Freedom Commission on Mental Health. In his capacity as the commissioner of the New York State Mental Health Office, he oversaw New York's $5 billion public mental health system. Previously, he served as the director of the Ohio Department of Mental Health and Commissioner of the Connecticut Department of Mental Health.

We thank you for being here, Dr. Hogan.

And for purposes of an introduction, now I'll turn to our Ranking Member, Senator Alexander.

Senator ALEXANDER. Thanks, Mr. Chairman. I am delighted to welcome Robert Vero from Centerstone of Tennessee. He's well known in our State. He has done work in the behavioral healthcare field for a long time, four decades. He's chief executive of the company, or nonprofit organization, the largest nonprofit community mental health centers. They have more than 50 facilities and 160

partnership locations. They serve nearly 50,000 people of all ages each year.

He has a distinguished academic background, which includes his work at Peabody College at Vanderbilt. He's a clinician. He's active and consulted by many for his expertise in this field, and I look forward to his insights about who needs help and how we can do a better job of making sure they get that help.

Thank you for being here, Dr. Vero.

The CHAIRMAN. Thank you, Senator Alexander.

Also for purposes of an introduction, I'll recognize the Senator from Colorado, Senator Bennet.

Senator BENNET. Thank you, Mr. Chairman, and it is a great privilege to introduce Mr. George DelGrosso to the committee. Mr. DelGrosso currently serves as the chief executive officer of the Colorado Behavioral Healthcare Council. The Council is a statewide network comprising 28 behavioral health organizations. It provides treatment and other services to over 120,000 Coloradoans each year. Mr. DelGrosso began his career as a psychotherapist. He then became a marriage and family therapist, and he was promoted to a clinical supervisor and program developer before ultimately moving into senior management.

Before leading the Colorado Behavioral Healthcare Council, Mr. DelGrosso served as the executive director of Mental Health Centers in the San Luis Valley in our State and in Cody, WY. Throughout his career, Mr. DelGrosso has worked to improve training and to develop integrated treatment approaches to mental healthcare. Currently, he is working to expand the Mental Health First Aid Program in Colorado to improve prevention, early identification, and access to care for those suffering from mental illness.

His decades of experience within the mental healthcare system give him a unique perspective on our discussions today. And it's in that spirit that I'd like to welcome Mr. DelGrosso to the committee, and I look forward to his testimony.

The CHAIRMAN. Thank you, Senator Bennet.

And now we have also Mr. Larry Fricks, a Senior Consultant at the National Council for Behavioral Health. Mr. Fricks is also the Director of the Appalachian Consultant Group and Deputy Director of the SAMHSA–HRSA Center for Integrated Health Solutions. He will share with us his firsthand account of recovery from mental illness and substance abuse.

We thank you for being here, Mr. Fricks.

As with the last panel, your statements will all be made a part of the record in their entirety, and I'll ask you to sum up—we'll just go from Dr. Hogan down—in 5 to 7 minutes, so we can get to a round of questioning. I'll start with Dr. Hogan.

I read all your testimonies last night. They're just excellent, just excellent, every one of them.

I remember, Dr. Hogan, you talked about separate but unequal, mental health from what we call regular health, I guess, or the healthcare system. Welcome and please proceed.

**STATEMENT OF MICHAEL HOGAN, Ph.D., FORMER COMMISSIONER, NEW YORK STATE OFFICE OF MENTAL HEALTH, AND CHAIRMAN, PRESIDENT'S NEW FREEDOM COMMISSION ON MENTAL HEALTH, DELMAR, NY**

Mr. HOGAN. Well, thank you, Senator Harkin. I just have to start as others have by expressing appreciation on behalf of our community to the committee for focusing on this at this time. It's been quite a while. But the timing is now, for other reasons that I'll explain, and recent events, I think, make it the right time to pay this some concern, and we're particularly appreciative that this focus happens on Senator Alexander's first meeting as Ranking Member.

I will start my remarks by focusing on something that is subtle and often not apparent with respect to mental healthcare as provided, and that is to say that the mental health system started in asylums run by States without the support or involvement of the Federal Government in any way. And to some extent, as we focused on a movement from asylum to community, there was attention to the locus of care that was being transformed.

But what escaped attention was that care in separate programs and systems was still separate. That is changing before our eyes right now. And it's changing and accelerating in ways that we can't even see because of legislation that has already been discussed, first originating in this chamber with Senator Wellstone and Senator Domenici, to say that mental healthcare had to be a part of healthcare, no longer separate.

And then second of all, the Affordable Care Act took that parity legislation and baked it into all the changes in healthcare that are going forward. So we are at a time when mental healthcare is increasingly going to be part of healthcare, and this raises two major questions for me.

One of them is: Will we take time and attention to make sure that we get mental health right in the mainstream of healthcare? We're fumbling at that right now. I want to talk a little bit more about that.

The second is: As we move away from the separate system, will we pay enough attention to it and ensure that there is sufficient stewardship for it in States and so on—this is primarily a State problem—or will we recapitulate the institutionalization by walking in another direction that is well-intended but that forgets the people with the most serious needs?

Those, it seems to me, are the two major challenges that we face. And having said that, I want to just touch on a couple of points briefly in that context.

The first of those has to do with the imperative of trying to figure out how we can help primary care providers to deliver basic mental healthcare. We're not asking them to do the complicated stuff. But most primary care providers with a little bit of help can do an excellent job with most of the mental health conditions that people walk into their offices with, but they can't do it on their own. They've got to have a social worker or a nurse or somebody who can spend the time with people. Their practice has got to be paid a little for that. Medicare still doesn't do that very well.

We have to take steps toward what's now called integrated or collaborative care to make sure that we provide that care in pri-

mary care. Right now, more people get something for their mental health problems in primary care than get it from the entire separate mental health system. But it tends to be a day late and a dollar short and not to be very effective. Your chances of getting a diagnosis with depression if you walk into your GP's office are less than 50–50, and your chances of getting enough treatment to make a difference are about 15 percent. But with a little bit of attention, that problem can be resolved.

I won't comment too much on the problem of protecting the safety net as we go forward in this transition. But I think what I would say is what the committee's attention might be focused on, which is whether there are adequate standards for mental healthcare, not in SAMHSA, but in CMS as the system goes forward. Increasingly, in States right now, when you're concerned about mental health, you don't talk to the mental health director. You talk to the Medicaid director. And whether they have this on their radar screen is sort of a coin flip, and Federal standards there would help.

The committee has already talked significantly about children's issues. And Senator Alexander's example of that 17-year-old with an early psychotic symptom, that Senator Murkowski also talked about, is something else that I want to comment on.

We know how to address those problems today and we do not. We know how to engage people in care with an early psychotic problem as we would, in a sense, in a modern cancer center. Family would be welcome. We'd look at a longitudinal plan of care. We would stick with people to try to find something that was acceptable to them, as opposed to waiting until they deteriorate, putting them in a hospital, letting them leave with a referral to care. That is just not going to work.

I have two other points that I've addressed in my written testimony, and my time is up. So I won't comment on them, other than to say I really want to underline what Senator Murkowski has said about the problem of suicide. Administrator Hyde and the Surgeon General have really stepped up on this. The Department of Defense and Veterans Affairs are moving on this. The rest of the Government should pay a little bit more attention because it's costing us more lives lost from suicide every week than we lost to military suicides in the entire last year.

Thank you.

[The prepared statement of Mr. Hogan follows:]

PREPARED STATEMENT OF MICHAEL F. HOGAN, PH.D.

SUMMARY

A decade ago the commission appointed by President George W. Bush to review mental health care said "the mental health services delivery system is in shambles." Just 10 years later, both problems and solutions are clearer. Mental health parity with the ACA moves mental health to the mainstream of health care. We must capitalize.

• *Integrating mental health care into health care is a big opportunity that could easily be missed*. Most Americans with mental health problems get no treatment. More people are treated in primary care than by mental health specialists, but this care is poorly paid for and often inadequate. Collaborative care is a proven approach to integrated care. It would be timely and very helpful if the committee were to track progress toward integrated care.

• *Protecting the safety net for individuals with serious mental illness is essential as we move to integrate care*. While budget cuts have been damaging, in many

States the mental health safety net is better and more focused than it was a quarter century ago. We do not yet have national standards for the quality of care for people with serious mental illness. Without such standards the transition away from expert leadership is risky. We must not repeat the errors of deinstitutionalization in the correct and optimistic move to integration. More robust national standards for mental health within Medicare and Medicaid would help.

- *Children's mental health care must be improved*. Mental health problems have been called "the major chronic diseases of childhood." Mental illness usually emerges before young people enter high school, but the average lag to treatment is 9 years. Reform presents major opportunities. Practical steps include: (1) screening for and treating maternal depression, (2) helping pediatrics and child mental health programs to provide holistic care, (3) upgrading performance standards for child mental health care within health care plans and programs, and (4) improving school mental health services using only research-tested approaches.
- *We must develop a national approach for effective early treatment of psychotic illness*. Our Nation's approach to helping people with psychotic illnesses like schizophrenia is shameful; better approaches have been tested in the United States and implemented widely in Australia and Great Britain. The committee's attention to this issue would have a positive effect.
- *Lifelong disability for people with mental illness is common, but usually unnecessary*. Supported employment for people with mental illness is effective but underutilized. The Federal Government, with leadership from the Social Security Administration and the Centers for Medicare and Medicaid Services can change this and reduce needless disability.
- *Suicide prevention: Now is the time to act*. Deaths by suicide in the Armed Forces last year exceeded combat deaths. Sadly, this is but the tip of the iceberg; twice as many American lives are lost to suicide in the average week than to military suicide during all of 2012. The Affordable Care Act offers numerous opportunities to incorporate best and effective practices for suicide prevention into Medicare and Medicaid, and into reform more broadly. The committee's attention could help assure that other Federal agencies beside SAMHSA and the Department of Defense are focused on preventing suicide, that the National Action Alliance for Suicide Prevention is sustained and that the national network of crisis lines that can be reached at 1–800–273–TALK is strengthened. These steps would be life-saving.

The mental health community greatly appreciates the committee's attention at this crucial time.

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The mental health community appreciates the attention of the committee, and the concern for consumers, families and providers that it represents. Mental health needs are substantial, but such attention from policymakers is rare.

What is the state of the mental health system? A decade ago, a commission appointed by President George W. Bush to review mental health care told the President that despite the efforts of many dedicated people "the Unites States mental health services delivery system is in shambles." While many of the challenges we addressed still exist, problems and solutions are clearer a decade later. I hope we can provide you with a helpful picture of them.

*Much has changed, while much appears to remain the same*. The Nation's mental health system had its origins in the asylums of the 19th century. While much has been said about the balance between institutional and community care, a bigger issue is that for most of our history, mental health care has been separate from health care—and also unequal. In the best recent study of mental health policy, Richard Frank and Sherry Glied assessed whether people with a mental illness were better off early in this century than 50 years earlier. They answered that question in the name of their monograph: "*Better, but not well*." However, the main insight from their study is that the improved well-being of people with a mental illness is not mainly due to changes within mental health care. Rather, the well-being of people with mental illness improved as they gained access to mainstream benefits like health care, disability insurance and housing. Improvements within the mental health system, like new treatments, had a smaller effect.

This trend has now accelerated. A major example is legislation known by the two outstanding Senators, a political odd couple united by concern for mental health, who sponsored it: Pete Dominici and Paul Wellstone. The 2007 passage of the *Mental Health Equity and Addictions Parity Act* (MHEAPA) was not about improvements within the mental health system. It was about including mental illness care in health care. It signaled that a separate and unequal mental health system was not an adequate solution.

Mental health care was also greatly enhanced by passage of the *Patient Protection and Affordable Care Act* (ACA). Building on Dominici-Wellstone, the ACA included mental health within its changes to health care. These two pieces of legislation are game changers for mental health. The inclusion of mental health will lead to profound changes that will play out over the next generation. Because health care is so complex and change is unpredictable, there will be false starts and dead ends. But any assessment of the state of America's mental health system must begin with a realization that we have begun to take big steps away from an approach that was both separate and unequal. The major challenges facing us are first whether including mental health in health care can be done sensibly, and second whether the portions of the mental health safety net that have value can be sustained. Inclusion creates big opportunities that we can seize or let slip away. In an earlier era of deinstitutionalization, we did not sustain our commitments to those most in need during change. Can we get it right this time?

*Integrating mental health care into health care*. A first major challenge for the next decade is to integrate basic mental health care into primary care. (Integrating primary medical care into mental health centers is also important, but not my major focus here.) We know that most Americans with mental health problems get no treatment for these problems. We also know that more people are treated by their family physician or other primary care practitioner than by mental health specialists. The problem is that we have many unmet needs while many specialty mental health programs are at capacity. The opportunity before us is that health coverage that includes mental health care will become available for many Americans. We must use this opportunity to provide integrated primary care that includes basic mental health care. There is less stigma in visits to primary care. People with a chronic illness like diabetes, cancer or hypertension who also have depression have health care costs at least 50 percent higher; and good basic mental health care reduces overall costs. Improving basic mental health care in primary care is a huge need and opportunity.

It will not occur automatically. Mental health care within primary care today is often inadequate. It can be done well, improving health and reducing costs, but barriers must be addressed. For example, "carved out" benefits for mental health care can usually be used only if a specialist is seen. Across primary care settings that have not upgraded to provide integrated care, less than half of the patients with a mental health problem get a mental illness diagnosis and treatment. Payments and supports for basic mental health care in primary care are often lacking, so less than 15 percent of the people with depression in primary care get adequate care. As a result, people with medical conditions like diabetes or high blood pressure as well as a mental health concern have bad health outcomes and higher medical costs.

We have an opportunity to address this problem because many people with these conditions will now have insurance that includes mental health care, and because practical ways to deliver basic mental health care in primary care settings are now well established. The approach, known as collaborative care, improves both health and mental health outcomes and also reduces total costs. Collaborative care is research tested and replicated in many real world clinics. The move to integrated care takes work, but its core elements are not complex: station a mental health practitioner in the practice, screen for mental health problems, measure progress, allow billing for basic mental health services like educating patients about managing their depression and ensure a psychiatrist or other specialist is available for consultation.

While collaborative care is proven, barriers to integrated care like separate benefits that are not available to primary care must be addressed. For collaborative care to work, the primary care setting must have its costs covered, including the modest additional costs of providing integrated care. There are also barriers in Federal standards. Medicare still does not pay adequately for the elements of collaborative care, despite the terrible burden of depression and other mental health challenges for older Americans. National screening recommendations are also outdated. They say, in effect, "If you have plenty of resources to treat depression, you ought to screen for it." This is ridiculous. In my view, removing obstacles to primary care treatment of basic mental health problems is a core element of getting mental health parity right. It would be timely and very helpful if the committee were to track progress toward integrated care.

*Protecting the safety net*. While health reform creates opportunities to improve care for many Americans, the safety net for individuals with the most serious mental illness is very stressed. This system, which evolved from State asylums and mental health centers to a diverse array of community-based treatment, rehabilitation and support services, is directed and managed at the State and sometimes the county level. Its financing depends on Medicaid and State general funds. And given State budget shortfalls, resources have been cut. The National Association of State

Mental Health Program Directors (NASMHPD) indicates that State mental health funding was reduced by more than $4 billion between 2009 and 2012.

While these cuts have been damaging, in many States the mental health safety net is stronger than it was a quarter century ago. Dedicated providers as well as State and local officials have learned what works. For example, we understand that decent, safe and affordable housing is a foundation for recovery, and a "Housing First" approach that first finds homeless mentally ill people a place to live and then assists with health and mental health has become a usual approach. We understand that people in recovery from mental illness and addiction working as "peer specialists" play an invaluable role as staff of community agencies. Many community mental health agencies are also integrating medical services into their mental health clinics, to address the co-occurring medical problems of the people they serve. So while the mental health safety net is stretched to the limits, it is better focused and more relevant than in the past.

There are threats to the safety net as health reform proceeds. Budget cuts have taken their toll, and we hope that as States move past budgets depleted by the recession there will not be further deep cuts. But there is also a concern about the erosion of informed leadership for the safety net system. Within States, as Medicaid has become the dominant payer for mental health services, the mantle of leadership is swinging away from mental health (and addiction) agencies toward Medicaid and Health agencies. A similar trend is occurring at the level where health care is managed; there is a movement toward managed care and within managed care there is movement from specialty behavioral health plans to mainstream managed care. The question is whether we can sustain the focus on quality of care for those most in need during this transition. We do not yet have national standards for the quality of care for people with serious mental illness, so the transition away from expert leadership is risky. We failed to maintain focus during an earlier era of deinstitutionalization; we must not make this mistake again.

*Children's mental health care*. Mental health problems have been called "the major chronic diseases of childhood." Mental illness usually emerges before young people enter high school, but the average lag to treatment is 9 years. Only about a quarter of children with mental health problems see a mental health professional, and often not enough care is delivered to make a difference. At the same time, we are scandalized by reports showing increased levels of psychiatric medication use among children, often with no adequate counseling to supplement or as alternative to medications. We see the results of insufficient mental health care in school failure and youth suicide. How do we do better?

While the gaps in children's mental health care are huge there is also reason for hope. In part, this is because we know more about what works, and what doesn't. We must start applying this knowledge. The timing is right if we act as we should; there are opportunities in healthcare reform and in calls to improve school mental health care. But like improvements to mental health care in primary care, improvement will not occur unless steps like these are taken:

- *Make screening for and treating maternal depression standard for the first 2 years after birth*. Maternal depression is prevalent, treatable, and can lead to big problems in development of the young child if left untreated. Treating mom's depression reduces levels of mental health problems for her children by half!
- *Help pediatric practices and child mental health programs to provide holistic care*. Noted columnist David Brooks—scarcely a bleeding heart liberal—has written persuasively of the problem of children growing up without the ability to "self-regulate"—to manage themselves and their own behavior. These skills can be taught—but only if we begin early by providing structured support to young parents. To do this, we need to be able to:
    - Begin therapy for children without a specific diagnosis—to reduce the chance that a serious diagnosis will be given later.
    - Allow comprehensive pediatric practices and child mental health programs to bill for parent training and support for behavior management—to reduce the use of major medication use after the behavior has gotten worse.
    - Reimburse and support team-based care in pediatrics including physician attendance at team meetings with families.
    - Reimburse pediatric and child mental health programs for care coordination with schools and other agencies; care coordination may be more effective and cost-effective than layering on additional treatments.
- *Put better performance standards in place for child mental health programs*. Right now national standards are limited to ADHD and followup after hospitalization. Adolescent depression indicators are being developed but are not yet approved or used. What doesn't get measured in health care often doesn't get done.

• *Do school mental health right*. The President's proposals following the tragedy in Newtown include significant expansion of school mental health. Done right, this could be a significant benefit. But we now know more about what is effective, and what isn't. Expanded programs should only use proven approaches, such as peer-assisted learning, and cognitive behavioral interventions for trauma, adapted for schools. Each of these approaches has been linked to improving educational outcomes.

*Develop a national approach for 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 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 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 will 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.

*Lifelong disability for people with mental illness is usually unnecessary*. While many of the worst outcomes of serious mental illness (e.g. homelessness, comorbid medical illness, incarceration) are receiving increased attention, we are failing systematically to help people escape poverty and disability. In effective supported employment approaches such as Individual Placement with Supports (IPS) a majority of adults with serious mental illness find a job. But we generally fail to use this effective program. The Nation's Vocational Rehabilitation (VR) system is focused on employment for people with disabilities, but it is limited in scope and flawed in its approach to helping people with mental illness. Most people with serious mental illness never get VR services, and among those who do, outcomes are worse than for other groups of people with disabilities. Most VR programs do not use IPS systematically. Meanwhile, Medicaid does not pay for key components of IPS. Because of these cracks between systems, an effective approach is usually not made available, and the employment rate among people with serious mental illness who are receiving care is, scandalously, about 15 percent.

Supplemental Security Income (SSI) and, for those who become disabled after working, Social Security Disability Income (SSDI) are invaluable lifelines for people with serious disability including serious mental illness. But many people with mental illness on SSDI and SSI want to work. And most could work—at the very least in part-time private sector employment—if IPS was available and if disability was not an "all or nothing" program.

I would like to bring to the committee's attention an innovative program established by New York State and the Social Security Administration to address this problem. It takes advantage of Ticket To Work—a well-intended back-to-work incentive program that has never reached its potential, largely because of its complexity. The New York State Office of Mental Health (OMH) in collaboration with the New York Department of Labor and other State agencies serving people with disabilities developed a comprehensive employment system for people with serious mental illness and other disabilities. Key components include: (1) education and counseling on benefits (such as how to maintain Medicaid coverage while working, and how to

take advantage of complex Social Security work incentives); (2) an integrated information system that links people to and is built onto the Department of Labor's workforce system; and (3) a statewide network of IPS services delivered through OMH Personalized Recovery Oriented Services (PROS) programs. Via a unique partnership agreement, the Social Security Administration has designated this system including all participating consumers and providers as a Ticket To Work *Employment Network*. This arrangement is the most systematic statewide approach to employment services and to fully using available benefits to support productivity instead of poverty and disability.

I urge the committee's attention to the costs and consequences of unnecessary disability for people with serious mental illness, in particular to:

- Assuring that Vocational Rehabilitation and Medicaid figure out how to make effective Individual Placement with Supports services available to all people with serious mental illness who want work instead of poverty, and
- How the Social Security/New York partnership can be implemented in other States.

*Suicide prevention: Now is the time to act*. We are dismayed by reports that deaths by suicide in the Armed Forces last year exceeded other combat deaths. This concern is surely justified. Yet this is but the tip of the iceberg; twice as many American lives are lost to suicide in the average week than to military suicide in a year. Suicide, which is the tenth leading cause of death—and the third leading cause of death among young adults—receives a relatively small investment in terms of research and programming than other public health problems of its magnitude. We can and we must do more.

The Administration, to its credit, has begun to focus on suicide prevention. In 2010, Secretaries Sebelius and Gates launched the Action Alliance on Suicide Prevention, a public-private partnership co-chaired by Army Secretary John McHugh and former Senator Gordon Smith. With support from the Action Alliance, Surgeon General Regina Benjamin has released a comprehensive update of the National Strategy on Suicide Prevention, originally released in 2001. Yet more action is needed. Suicide prevention activities are scattered and thin. Outside the Department of Defense, the only national efforts are the National Suicide Prevention Lifeline (1–800–273–TALK), a technical assistance center, and the small network of youth and college prevention programs funded by the Substance Abuse and Mental Health Services Administration under the Garrett Lee Smith Memorial Youth Suicide Prevention Act.

It is time to do more to fight this needless and often preventable form of death. It is claiming the lives of students, soldiers, veterans, and Americans of every age and background. Congressional action would help advance this cause, as it did with passage of the Garrett Lee Smith Act. The Action Alliance is focusing integrating state-of-the-science suicide prevention practices into initiatives under the Affordable Care Act. We assess that current clinical practices in the United States are one to two decades behind the research, which demonstrates that effective care, what we call "suicide care," targeted to patients who are at risk, can significantly improve their prognosis. The Affordable Care Act offers numerous opportunities to incorporate best and effective practices into preventive services offered through Medicare and Medicaid, into electronic health records, and into other reform initiatives.

Suicide prevention is an area where small amounts of money can make a difference. The Action Alliance has the potential to bend the curve on suicide, but it is funded this year via a time-limited grant from SAMHSA. Similarly, the Nation's network of certified crisis lines, although linked together by the SAMHSA-funded Lifeline project, is mostly funded by State and local-level grants and philanthropy, yet it is projected to respond to a million callers this year, a large proportion of whom are in utter desperation and on the threshold of their own death. Research has conclusively shown that these crisis lines are effective and are performing as an indispensable part of the Nation's health care system, yet they receive no Federal support. The committee's attention could help assure that other Federal agencies do more to help, that the National Action Alliance for Suicide Prevention is sustained and that the national network of crisis lines is strengthened. These steps would be life-saving.

*Conclusion*. We thank the committee again for focusing on mental health needs and opportunities, and we hope our suggestions are relevant and helpful. Some of the issues I discuss do not necessarily suggest easy fixes. But mental health concerns are coming out of the shadows, at a time of major change in health and mental health care. Now is the time to get it right. We face major opportunities to improve health care for millions of Americans, but these are opportunities that can easily be missed. Similarly, we cannot allow what remains of the Nation's mental

health system for people with the most serious disorders to be dissipated. In an earlier, failed era of deinstitutionalization, patients were dumped into unprepared communities. This is not the time to dump them again, into "mainstream" arrangements without adequate protections and accountabilities. Fixing the mental health system requires more than gun control. And it is possible.

The CHAIRMAN. Thank you very much, Dr. Hogan.
And now we'll turn to Dr. Vero.

**STATEMENT OF ROBERT N. VERO, Ed.D., CHIEF EXECUTIVE OFFICER, CENTERSTONE OF TENNESSEE, NASHVILLE, TN**

Mr. VERO. Thank you, Senator Harkin.
Thank you, Senator Alexander.
On behalf of Centerstone and my colleagues in behavioral health throughout this country, I again want to echo how much we appreciate the attention that community behavioral health and healthcare, in general, is receiving as a part of this hearing. You know, I hope that what I share will assist this committee truly as you seek to gain an understanding of the opportunities to address the gaps and barriers that we know currently exist in the mental health system.

It's been echoed several times this morning that we know that, recently, our country absolutely suffered the devastating loss of 28 precious lives, 20 innocents, 6 courageous teachers and administrators, a mentally ill young man who did not get the care that he needed, and his mother who did not get the care nor the information that she needed. This tragedy, along with those in Colorado, Arizona, California, Virginia, and others, has thrown a very invaluable spotlight on community mental health, mental illness, and this entire discussion.

To work in this area of community mental health is an extraordinary privilege. It's likewise a tremendous responsibility. I've been fortunate throughout the last four decades to participate in our field from a variety of perspectives, as a clinician, as a critical incident responder, as a faculty member, as a research collaborator, as a patient, and as a CEO. I've seen firsthand what the research shows. Mental illness affects everyone, and mental health treatment is effective.

Community mental health centers do a tremendous job for the people we serve. We change and save lives, helping to build strong, healthy, resilient individuals and strong, healthy, resilient communities. There are, however, several significant barriers and gaps in the current U.S. mental health system that make it difficult for our local agencies to serve as the safety net they were intended to serve by President Kennedy more than 50 years ago.

Most significant among these is the limited availability of quality mental health services for children and youth. Sadly, we lack a Federal definition of what services a community mental health center should offer. Consequently, many towns and cities, especially rural ones, do not have access to a continuum of care that covers the life span.

Since 50 percent of mental illnesses do occur before the age of 14, and three out of four people experience the initial onset of these illnesses by the time they reach young adulthood, the lack of early intervention can have tragic and lasting effects. Congress is encouraged to pass language similar to that included within the Ex-

cellence in Mental Health Act, defining that a community behavioral health provider must provide a full continuum of services across the life span. In particular, we wish to thank Senator Debbie Stabenow and Senator Jack Reed for their tireless leadership in this critical legislation.

There are several ways as well to address the barriers to providing quality children's services. Thanks to grant funding from SAMHSA and the Department of Education, Centerstone has been able to deliver home and school-based services within both urban and rural areas. These programs have proven clinically effective and likewise offset overall educational costs.

Congress could increase its support of Federal funding to effectively deliver prevention and early education services. Congress could ensure as well that services to children and youth target the entire family. Research shows that programs that engage the whole family are the most effective programs. Inadequate insurance coverage too often becomes the barrier to engaging the entire family.

Incredibly, not all States, counties, and community mental health centers offer formal crisis services, especially those services that are delivered 7 days a week, 24 hours a day, 365 days a year. The Excellence in Mental Health Act would also require the provision of these crisis services.

Technology, which we haven't talked very much about this morning, also prevents another barrier. Thanks to the work of the Office of the National Coordinator of Health IT and the leadership of Senator Sheldon Whitehouse, there have been tremendous advances toward creating standardized communication guidelines.

Unfortunately, since community mental health was left out of the 2009 HITECH Act, we have not been able to fully benefit from these advances. Strong bipartisan bills in both houses of Congress like those that have been introduced in the prior Congress by Representatives Murphy and Blackburn, and Senators Whitehouse and Collins would correct this problem.

With behavioral health IT, this is what community behavioral health would be able to do. We could effectively share information for purposes of coordination of care, including treatment plans, with primary care providers. We would prevent some of the drug-drug interactions that occur because of a lack of shared information and, hopefully, prevent over-prescribing. We could also effectively track outcomes over time.

There's a great need for integrating physical and behavioral healthcare in this Nation. We hear a lot about America's fragmented and broken healthcare system. The consequence, at best, is costly and, at worst, dangerous and too often deadly. People with serious mental illness, on average, die 25 years earlier than their non-mentally ill contemporaries. Is it because of their mental illness? No. It's because of the impact of their comorbid conditions, diabetes, cardiovascular disease, as examples.

Community mental health centers are key to improving physical healthcare by simultaneously lowering overall healthcare cost. Our expertise in behavior change is part of the solution to meet the triple aim of healthcare: reduced cost, improved health, and quality outcomes.

We are grateful that in 2009, SAMHSA launched its Primary Care and Behavioral Health Integrated Care Program and since has launched 94 programs across the country. Two have happened to land at Centerstone, which were very fortunate. The SAMHSA initiative seeks to improve the physical health status of people with serious mental illness and reduce their total healthcare cost by making sure services for behavioral health and physical health are provided at the same location.

We have a substantial and complex task before us. We cannot solve these issues alone as providers. This is a moment. This is a watershed moment that demands courage and action. Everyone in this room shares responsibility for the future of community mental health. Community mental health centers stand ready to work with you, our elected and representative officials, to make a difference in this U.S. mental healthcare system.

Thank you.

[The prepared statement of Mr. Vero follows:]

PREPARED STATEMENT OF ROBERT VERO, ED.D.

SUMMARY

Community Mental Health Centers do a tremendous job for the people we serve. We change and save lives, helping to build healthy, resilient communities. There are, however, several significant barriers and gaps in the current U.S. mental health system that make it difficult for our local agencies to serve as the safety net envisioned by President Kennedy, more than 50 years ago.

(1) Currently, many towns and cities, especially rural ones, do not have access to a **continuum of evidence-based services designed for children and youth.** Since 50 percent of mental illnesses start before the age of 14, and 3 out of 4 people experience the initial onset of these illnesses by young adulthood, this lack of early intervention can have tragic, lasting effects. The Excellence in Mental Health Act would require that community mental health centers offer a full continuum of care services to children and youth.

(2) There are **funding barriers** to ensuring that services to children and youth target the entire family. Research shows that programs that engage the whole family are most effective. There is innovative grant funding from SAMHSA and the Department of Education to support communities in adopting evidence-based prevention and early intervention services. However, sustainability is often difficult due to insurance coverage restrictions and regulations.

(3) Not all States, counties, and community mental health centers offer **24/7 mobile crisis services for children and adults.** The Excellence in Mental Health Act would also require the provision of these crisis services by community mental health centers.

(4) Since community mental health centers were left out of the **HITECH Act** and are often not included in local and State **Health Information Exchanges,** they currently lack the ability to efficiently share information for purposes of coordination of care; prevent over-prescribing, reduce medication errors; and, effectively track outcomes over time. There have been several bipartisan bills introduced, thanks to the leadership of Representatives Murphy and Blackburn and Senators Whitehouse and Collins, but it has not yet been made into law.

(5) Currently there is a **fragmented health care system** for persons with mental illness. Community mental health centers are key to improving physical health while simultaneously lowering health care costs. Our expertise in behavior change is part of the solution to meet the triple aim of healthcare—reduced cost, improved health, and quality care. SAMHSA's Primary Care and Behavioral Health Care Integration program addresses this fragmentation, but true sustainability for integrated care requires multifaceted changes from community mental health centers, States, managed care plans, and Federal regulations.

Community Mental Health Centers stand ready to work with you to improve the mental health system. However, we cannot solve these issues alone. We ask for leaders in the public and private sector to work with us as we seek to create a new future for mental healthcare.

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

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

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

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

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

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

Over the years, I have found this to be true in my own family as well, especially when my 40-year-old cousin, Lisa, took her own life. I wish she had been able to ask for help when her pain became unbearable because I know there is an alternative to senseless death. Mental health treatment is life-saving.

## ROLE OF COMMUNITY MENTAL HEALTH CENTERS

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

## BARRIERS & GAPS IN ACCESS TO HIGH QUALITY CHILD & ADOLESCENT SERVICES

One of the biggest barriers is a lack of access to services for children and youth. Sadly, due to a lack of a Federal definition of what services a community mental center should offer, many towns and cities, especially rural ones, do not have access to a safety net provider, offering a full continuum of evidence-based services to children and youth within a service area. Since 50 percent of mental illnesses start before the age of 14, and three out of four people develop their condition, including

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

bipolar disorder, depression and schizophrenia by young adulthood, this lack of access can have tragic, lasting effects.[2]

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

There are several ways to address this barrier:

- The most permanent fix would be to pass language similar to that included within the **Excellence in Mental Health Act** specifically defining that a community mental health center has to provide a full continuum of services across the lifespan—including early intervention services.
- **Grant funding streams** that encourage existing centers to expand their service continuum and partner with community organizations are also helpful. At Centerstone, due to grant funding from SAMHSA and the Department of Education, we have been able to offer mental health and substance abuse services within rural schools for children and youth. We are now co-located in 160 preschools, middle and high schools throughout Tennessee, serving as adjunct faculty and providing a service to the school, they would likely be unable to deliver without our partnership. In addition, we recently were awarded a grant for early intervention services for families of infants and toddlers at risk for emotional problems.
- Pass **Health IT legislation** so that community mental health centers, especially rural centers, can access telehealth services. With a severe and growing national shortage of child, adolescent, and adult psychiatrists,[5] telehealth is one of the key ways to foster improved access to services for children and adults with serious mental illness, especially in underserved and rural areas.

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

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

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

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

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

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

[4] Edwards VJ, Holden GW, Anda RF, Felitti VJ. *Experiencing multiple forms of childhood maltreatment and adult mental health: results from the Adverse Childhood Experiences (ACE) Study. American Journal of Psychiatry,* 2003;160(8):1453–60.

[5] American Academy of Child and Adolescent Psychiatry (AACAP). (2008) *Analysis of American Medical Association Physician Masterfile*. Washington, DC: American Academy of Child and Adolescent Psychiatry.

[6] National Research Council and Institute of Medicine. (2011) *IBID*

**Gaps between different care providing systems.** We hear a lot about America's fragmented health care system with current news focusing on mental health care. Children with serious emotional disturbances and mental disorders and their parents, in order to get the care they need, often have multiple providers and interface with multiple agencies (i.e. department of children's services, juvenile justice, pediatric office, school, mental health center, etc.) The consequence is at best costly, and at worst dangerous. Care coordination models have proven effective outcomes. We encourage the expansion of these evidence-based models.

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

TRANSITIONS IN YOUNG ADULT CARE

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

EXCLUSION OF COMMUNITY MENTAL HEALTH CENTERS FROM HITECH ACT

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

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

From the CMHC perspective, I do not know how centers can ensure that the care we are providing is what we would want for each of our family members without using Health IT tools. The first 25 years I spent in this field were with paper records, and I can tell you the difference between clinical supervision of paper records and clinical supervision using analytics tools is night and day. Thanks to the Ayers Foundation and the Joe C Davis Foundation, Centerstone was able to develop analytics tools similar to those used by for-profit businesses. With these tools, I can hotspot clinics, locations and centers where outcomes are lagging and rapidly develop localized quality improvement plans. I can ask questions like, "how many children are we serving in foster care and have been prescribed atypical antipsychotic medications in the last 3 months," or "how is our HEDIS client engagement metric last month compared to last year" and get the answer in 1 short minute.

As primarily Medicaid providers, most community mental health centers exist with very little financial margin, if any. Funding large health IT purchases is a luxury most cannot afford. Due to the contrary, due to the billions in cuts our field has experienced over the last 4 years, some community mental health centers have been forced to simply shut their doors while many more have quietly ended programs and laid off large numbers of employees.

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

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

NEED FOR FORMAL MENTAL HEALTH CRISIS SERVICES IN EVERY COMMUNITY

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

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

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

NEED FOR INTEGRATED CARE

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

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

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

Community mental health centers are key to improving physical health while simultaneously lowering health care costs. The same skills we use to prevent mental health hospitalizations can be used to prevent physical health hospitalizations. The same skills our clinicians use to promote behavior changes in depressive cognitive

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

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

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

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

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

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

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

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

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

## NEED FOR ADEQUATE AND CONSISTENT COVERAGE IN ACA

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

## CONCLUSION

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

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

Thank you for your time and attention.

The CHAIRMAN. Thank you very much, Dr. Vero. I appreciate that.

Now, Mr. DelGrosso, welcome. Please proceed.

**STATEMENT OF GEORGE DelGROSSO, M.A., EXECUTIVE DIRECTOR, COLORADO BEHAVIORAL HEALTH COUNCIL, DENVER, CO**

Mr. DELGROSSO. Thank you, Senators Alexander and Harkin, and you, Senator Bennet. You've always been there for us for mental health in our State, and I want to thank you for being there.

It's interesting this morning as I hear the discussions happening around the room, and I want to share two thoughts with you if I might. The first one is I think you may be surprised about how many people are watching CSPAN today from around the country because they're so excited about the opportunity to really discuss this matter in a kind of detail that we're really hoping for.

The second part of it is I'd like to share with you that if I could take a video of today and the comments that you all were making up there and the comments made down here today, and if we could sort of encapsulate it and play it to the public, and if that became the public message, we wouldn't have to be here today. I think people would be greatly moved by what all was brought here today and what you're saying about our area of healthcare and how important it is to address it, both mental health and substance use disorder.

Today I've been asked to talk about mental health first aid. There were several of you that said, "Tell us about what we might be able to do to intervene or to connect earlier," and that's what I'll be sharing. But I want to make sure, so I don't run out of time, to tell you that there are a couple of things that can be done.

One is that with the shortage of funding that has been in the area of mental health and substance use disorder, the funding that is available has really been focused on people who already have diagnosable conditions or are already significantly ill. And we need to ensure that we continue to provide care in those areas.

But what we're having problems with is when we do start doing prevention work in both the physical health area and the behavioral health area, often the codes and the funding are not available. So you have to take it out of your own pocket, in a sense, as a provider or the person themselves to try to get some of the necessary prevention and early intervention services and supports that they need to keep them from getting to that point. This is particularly a problem in the area of Medicare.

Today we haven't talked very much about the elderly. And I think a lot of people think because somebody is getting old that they're going to just naturally be depressed and it's a bad thing. But that's really not the reality. Many people are aging and doing well, but sometimes there is depression or they have substance use disorders just like anybody else, and they need the help and the care that they can get to be preventive and also to get the treatment.

Mental health first aid is an area in our State that we have a great deal of excitement about because of a couple of different reasons. No. 1 is that we saw the opportunity with mental health first aid to really get out into our citizenry and to be able to talk about mental health itself and increase their literacy and their understanding and recognition of the signs and symptoms of common

mental health diseases like bipolar, major depression, PTSD and anxiety disorders, as well as substance use disorders.

But it also provides crisis de-escalation techniques by the people who take the class. Just like physical health, first aid helps you in order to be able to bandage something or to splint if there is a broken leg. And then there's a five-step action plan to get persons in psychiatric distress referred to mental health providers. It's a very comprehensive program.

In the wake of the serious summer that we had, we often know about Aurora and the shootings there, but we also had two major fires in our State this past year, and a lot of people lost their homes and there was some loss of life. It was one of the most depressing summers we've had in Colorado for a long time, and it's a beautiful State to live in.

One of the things that we found is that by using mental health first aid, a lot of people began to reach out more for help themselves and to help their family members, and to understand more about what's going on with them and what's happening in the world around them.

I'll never forget meeting 1 day with Senator Udall and Senator Bennet and talking about the issues around mental health. And Senator Udall looked up and said,

> "What we need is a program to help us to sort of identify things for our family members and friends and in our churches and in our Government, ET cetera, when they need help."

And we said, "Sir, let us tell you about mental health first aid," and at that point, it became a real charge for us in Colorado.

It's interesting to note that our mental health first aid instructors have also done training with the Governor's cabinet, department heads and managers at many State agencies. And there is a consideration right now that all State employees will take mental health first aid. The Department of Corrections does this today. They have trainers, and all of their corrections officers are being trained.

I can go on and on about the number of people who have received this, but I want to let you know that there's some really great news coming out of Washington on this. Last week, Representative Ron Barber introduced the Mental Health Aid Act of 2013. That's H.R. 274. As you may know, he was wounded in the tragic incident in Tucson, and mental health first aid was also helpful in their area as they were recovering from their tragedy there.

We have it on good authority and anticipate that there is going to be a bill with bipartisan support coming through the Senate, and we would really ask that you consider supporting this as a committee and providing the funding that we so necessarily need in our community.

Again, I want to thank you so much. What a tremendous opportunity to be here today and speak on behalf of this area of healthcare. Thanks for your interest.

[The prepared statement of Mr. DelGrosso follows:]

PREPARED STATEMENT OF GEORGE DELGROSSO, M.A.

SUMMARY

George DelGrosso, the CEO of Colorado Behavioral Healthcare Council (CBHC) will testify on behalf of CBHC and the National Council for Community Behavioral Health Care (NCCBH). His testimony will be an overview of Mental Health First Aid (MHFA) a prevention and early identification program, that helps parents, family members, teachers, law enforcement, and others in the general public to understand and better identify someone who may be mentally ill or in mental distress and help them get necessary treatment before there are serious implications for the person and the community. This evidence-based program, similar to First-Aid programs taught by the American Red Cross for physical health, focuses on mental health and is available in various locations throughout the United States.

MHFA has proven to also be effective in Colorado to help communities cope in the aftermath of two major fire disasters, and a shooting in Aurora. CBHC received the NCCBH national award in 2012 for its implementation of MHFA instruction throughout most of the communities in Colorado.

Mr. DelGrosso will also briefly discuss additional concerns facing community mental health and substance abuse providers the HELP Committee may want to consider.

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Chairman Harkin and Senator Alexander, thanks for giving me the opportunity to appear before the Senate HELP Committee on behalf of the Colorado Behavioral Healthcare Council and the National Council for Behavioral Health. My name is George DelGrosso and I am the Chief Executive Officer of the Colorado Behavioral Health Council (CBHC).

The CBHC is a statewide organization composed of 28 behavioral health organizations including all of the 17 Community Mental Health Centers, 2 specialty mental health clinics, 4 managed service organizations and 5 behavioral health organizations. The latter organizations are the management entities throughout the State for substance use disorder and the State's Medicaid mental health managed care program.

Our members provide psychiatric care, intensive community-based services and addiction treatment to over 120,000 Coloradans each year. About 50 percent of our mental health center consumer/patient caseload is composed of adults with severe mental illnesses like schizophrenia and bipolar disorder. We also serve children with serious mental and emotional disturbances referred to us by their families, the Colorado juvenile justice, special education and foster care systems.

I will be devoting the bulk of my testimony today to the Colorado Mental Health First Aid program because we believe that it's an exciting new public health approach to early identification of mental illnesses and other mental health disorders. You will hear other witnesses testify today that mental disorders often begin manifesting themselves by as early as 14 years of age. According to the American Psychiatric Association Diagnostic and Statistical Manual, the first obvious symptoms of severe mental illnesses occur between ages 18 and 24. But, on average, it takes us 8 very long years to begin mental health care for these Americans. By the time treatment does begin, the costs of mental health care services are higher and their clinical effectiveness is reduced.

That's why both the National Council and the CBHC are so excited about Mental Health First Aid. It is an evidence-based practice that represents an early intervention and early detection program that—if implemented broadly enough—could permit America's community mental health providers to help millions of our fellow citizens in psychiatric distress. In brief, Mental Health First Aid teaches a diverse array of audiences three important sets of skills:

- Recognition of the signs and symptoms of common mental illnesses like bipolar disorder, major clinical depression, PTSD and anxiety disorders.
- Crisis de-escalation techniques.
- A five step action plan to get persons in psychiatric distress referred to mental health providers including local Community Mental Health Centers.

In sum, this training is somewhat similar to first aid classes taught by local chapters of the Red Cross for physical health conditions.

In our State, we receive some funding from the Colorado Office of Behavioral Health, which is the State mental health authority, and use Community Mental Health Center resources to provide Mental Health First Aid in various locations through out Colorado. People who want to attend a Mental Health First Aid class can log on to a Web site, or contact their local mental health center and enroll in

classes happening in their local communities. All of our Community Mental Health Centers have trained Mental Health First Aid instructors.

As I indicated at the outset, a diverse array of training audiences is key to the program's public health approach. For example, Mental Health First Aid Instructors have conducted trainings with the State Sheriff's Association and the Colorado Department of Corrections. In fact, the DOC has a goal of training all their corrections and parole officers.

The committee might be interested to know that we've trained Governor Hickenlooper's cabinet members, department heads, and the middle managers at many State agencies. CBHC is currently organizing Mental Health First Aid training for all the rabbis in the Denver Metropolitan Area. We would also like to extend the training to schools districts and institutions of higher education throughout the State. The ultimate goal is to increase the understanding of mental health issues, help our citizens be able to identify when a friend, co-worker or family member is having mental health distress, and help them get involved in treatment when it is necessary. Someday we hope to see Mental Health First Aid Instruction as common place as physical health first aid.

In all candor, the tragic movie theater shootings in Aurora, CO added a strong impetus to all these efforts in Colorado. Indeed, in the aftermath of the enormous tragedy at Sandy Hook Elementary School in Newtown, CT, there has been an outpouring of bipartisan support for improving the mental health care system in this Nation. Voices as diverse as the *Wall Street Journal* editorial page, the libertarian Cato Institute, President George W. Bush's former speech writer and, now, Vice President Biden's Gun Violence Task Force have all endorsed various proposals to enhance mental health care in schools and improve services for people with severe mental disorders. In fact, the task force explicitly endorsed Mental Health First Aid.

We note that there is a common policy thread running through all these proposals. In some form or fashion, they all endorse "early detection" of mental illnesses. The National Council and CBHC strongly endorse Mental Health First Aid because—from a prevention standpoint—that is exactly what the program does. It permits us to intervene early in the lives of individuals who later may be in desperate need of more intensive community-based mental health services.

Last week, Representative Ron Barber introduced the Mental Health Aid Act of 2013 (H.R. 274). Congressman Barber was grievously wounded in the tragic Tucson, AZ shooting that almost took the life of former-Representative Gabrielle Giffords and left six other persons dead including a 9-year-old girl. We have it on good authority that Senator Mark Begich will soon introduce the companion bill in the U.S. Senate. He will be joined by Senator Kelly Ayotte from New Hampshire.

In a recent letter to Vice President Biden, Congressman Barber wrote the following:

> "I urge you to endorse common-sense, bipartisan proposals like the Mental Health First Aid Act. We have failed to give the mental health care needs of Americans due attention for too long—and we paid too high a price for this neglect."

In the perhaps divisive legislative debate to come, we hope that the Senate HELP Committee can come together to enact the "common sense, bipartisan proposals" that Representative Barber referred to in his correspondence to the vice president.

Again, thanks for the opportunity to testify. I am happy to answer any questions you may have.

The CHAIRMAN. Thank you, Mr. DelGrosso.

And now we turn to Mr. Fricks. Welcome and please proceed.

## STATEMENT OF LARRY FRICKS, SENIOR CONSULTANT, NATIONAL COUNCIL FOR BEHAVIORAL HEALTH, CLEVELAND, GA

Mr. FRICKS. Thank you, Chairman Harkin and Senator Alexander. It's an honor to be here and an honor that we're getting this sort of focus on those of us that experience mental illness and addiction.

I'd like to address three topics today: first, the stigma and discrimination that surround behavioral health disorders; second, the critical role of peer support and a new workforce in our country called peer specialists that promote recovery; and, third, the impor-

tance of whole health. Mind-body has been huge in my recovery from bipolar illness. So those are the three topics I'd like to address.

First of all, I am someone recovered from bipolar illness. I'm also clean and sober 28 years. And I can tell you and my peers can tell you that we fight two battles. We fight the illness, but we also fight the stigma. We have a saying in our movement: What you believe about mental illness may be more disabling than the illness itself. And yet as a society we largely remain ignorant about the signs and symptoms of mental illness, and we ignore our role as supportive community members to help those of us experiencing those illnesses.

I was hospitalized three times in the mid-1980s. I fall in the category of a serious mental illness. I've ridden in the back of a deputy's car. It's a very humiliating experience. I spent a day in jail because of my psychosis until family and friends intervened and got me help, and I attempted suicide. So you can see it is humbling to be here today and have a chance to talk about this.

What happens is the stigma is so significant that we often internalize it. It takes over our lives. It's not only the diagnosis, but it becomes the prognosis that your life is over as you've known it. And yet today I live a full and meaningful life. I have a wonderful wife and a life in the north Georgia mountains. Key to that was learning self-management skills. I haven't heard anything about self-management. Those of us in recovery know about self-management to stay well. Peer support is huge, having somebody that you can relate to, and also receiving services.

Now, the future is mind-body. I just want to say that learning about sleep deprivation and its role in bipolar illness was huge for my recovery. And it was a former director of NIMH, Dr. Fred Goodwin, that introduced me to that. I manage my bipolar illness largely by managing my sleep patterns and being very careful. I fly almost every week, and I'm very careful.

So this new workforce of certified peer specialists—in Georgia, for 13 years, I served on the management team for the State Department of Behavioral Health and Developmental Disabilities. They're the fastest growing workforce in our State. We've trained nearly 1,000. There's probably been 12,000 trained across the country.

We focus on what we call strength-based recovery and whole health. We're able to deliver services that are Medicaid billable if the service is included in the State plan. And research on the effectiveness of peer specialists has been so positive that in 2007 the Centers for Medicare and Medicaid Services issued guidelines for States wanting to bill for peer support services, proclaiming them as an evidence-based model of care.

Research shows that we have a unique ability as peer specialists to connect with other peers to ignite hope and teach skills for recovery, self-management, and promoting whole health. However, I would warn you that Medicaid's focus on medical necessity makes it tough, because we are strength-based and we look at unlocking hope and self-management. So it's a little tough to fund under medical necessity. We'd like to see more flexible funding for that.

Peer respite centers are springing up across the country staffed by us. If you're feeling early warning signs, you can go in. We have three of them in Georgia. You can spend up to 7 nights surrounded by peers, and it's keeping people out of hospitals. We're having tremendous success in Georgia. We're under a Department of Justice settlement for deaths in our hospitals, so this is a service that we have that is really starting to pay off.

Then addressing this mind-body healthcare, there can be no health without mental health. Conversely, we cannot successfully care for people with mental health and addiction disorders without addressing their co-occurring physical health disorders. Research indicates that people with severe mental illness in the United States who are served in the public healthcare system have an average life expectancy that is 25 years less than the general public. We've heard that already. We're dying in the early 50s, many of us.

So I just want to thank SAMHSA. They're working to address this by providing grants to the community behavioral health centers for offering basic primary care screenings and coordinating referrals to primary care. As part of the Primary Care Behavioral Health Integration Program, nurses, trained care managers, peer specialists, and other healthcare professionals are now actively working in 94 grantee sites to screen patients for weight gain, blood lipid levels, cholesterol, teach skills for whole health self-management and more.

And although data is still being collected, early results indicate that this program has been successful. It is helping people with behavioral health conditions maintain or reduce their weight, cholesterol, blood sugar, and other risk factors for chronic disease. I strongly urge the committee to support this important grant program.

In closing, I'd like to say that after nearly three decades of experience in behavioral health, it has taught me that the greatest potential for promoting recovery and whole health comes from within the individual, with the support of peers, family, and community. My recommendation is to establish and support programs that drive this potential, putting the person at the center of all services, building on their strengths and supports.

Thank you very much.

[The prepared statement of Mr. Fricks follows:]

## Prepared Statement of Larry Fricks

### Summary

Good morning, and thank you for inviting me to speak at today's hearing. I'd like to cover three topics: first, the ongoing stigma and discrimination that surround behavioral health disorders; second, the critical role of peer support to promote recovery; and third, the importance of a whole health approach when it comes to improving our healthcare system.

Allow me to share with you today some of my lived experience of recovery from mental illness and substance abuse over the last 28 years. As anyone who has experienced a mental health or substance use condition can tell you, we must fight a battle on two fronts: one against the diagnosis itself, and the other against public ignorance. I was hospitalized three times in the mid-1980s. When I returned home from my last hospitalization I sank into deep despair. I internalized the stigma and discrimination experienced from mental illness, growing a negative self-image and sense of hopelessness from the prognosis that my life was over as I knew it. Yet

today, I live a full and meaningful life because I was able to learn self-management skills, gain peer support, and receive mental health services with a focus on mind-body recovery. Members of the committee, I urge you to support public education programs that reduce stigma and discrimination by helping Americans learn how to reach out and support their friends and family members who may be experiencing a behavioral health condition.

Next, I'd like to share some information about certified peer specialists, who use their lived experience and are trained in skills to promote strength-based recovery and whole health, delivering services that are Medicaid-billable when included in State plans. Research on the effectiveness of peer specialists has been so positive that in 2007, the Centers for Medicare and Medicaid Services issued guidelines for States wanting to bill for peer support services, proclaiming them "an evidence-based model of care." Research shows peer specialists are unique in their ability to connect with other peers to ignite hope and teach skills for recovery, self-management, and promoting whole health. However, because Medicaid requires "medical necessity" in documenting illness and symptoms—and peer specialists are trained to focus on strengths and supports—we need more flexible funding sources to grow the recovery and whole health outcomes that peer support services can deliver.

This brings me to the final point I'd like to discuss: the importance of addressing the mind-body connection in healthcare. There can be no health without mental health. Conversely, we cannot successfully care for people with mental health and addiction disorders without addressing their co-occurring physical health disorders. The Substance Abuse and Mental Health Services Administration is working to address this issue by providing grants to community behavioral health centers for offering basic primary care screenings and coordinating referrals to primary care. As part of the Primary Care-Behavioral Health Integration program, nurses, trained care managers, peer specialists, and other healthcare professionals are now actively working in 94 grantee sites to screen patients for weight gain, blood lipid levels, cholesterol, teach skills for whole health self-management, and more. Although data is still being collected, early results indicate that this program has been successful in helping people with behavioral health conditions maintain or reduce their weight, cholesterol, blood sugar, and other risk factors for chronic disease. I strongly urge the committee to support this important grant program.

In closing, I would like to say that nearly three decades of experience in behavioral health has taught me that the greatest potential for promoting recovery and whole health comes from within an individual, with the support of peers, family and community. My recommendation is to establish and support programs that drive this potential, putting the person at the center of all services, building on their strengths and supports.

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Good morning. Thank you, Chairman Harkin and Senator Alexander, for inviting me to speak at today's hearing. My name is Larry Fricks. I am a senior consultant to the National Council for Community Behavioral Healthcare and deputy director of the SAMHSA—HRSA Center for Integrated Health Solutions. I'd like to cover three topics today: first, the ongoing stigma and discrimination that surrounds behavioral health disorders and the need for better public education regarding the facts about mental illness and addiction; second, the critical role of peer support to promote recovery; and third, the importance of a whole health approach when it comes to improving our healthcare system.

As former First Lady Rosalynn Carter said, "stigma is the most damaging factor in the life of anyone who has a mental illness." Stigma is our biggest challenge.

Allow me to share with you today some of my lived experience of recovery from mental illness and substance abuse over the last 28 years, focusing on peer support and the skills I learned to self-manage my mind-body health. As anyone who has experienced a mental health or substance use condition can tell you, we must fight a battle on two fronts: one against the diagnosis itself, and the other against public ignorance. According to data from the Substance Abuse and Mental Health Services Administration (SAMHSA),[1] one in five Americans will experience a mental health issue during any given year. Yet, as a society, we largely remain ignorant about the signs and symptoms of mental illness, and we ignore our role as supportive community members to help people experiencing these illnesses.

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[1] 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.

My grandmother, Naomi Brewton, graduated from the top of her class in college. But when she gave birth to her youngest son, she suffered what was then called a "nervous breakdown." Her father was Dr. Brewton, founder of Brewton-Parker College near Vidalia, GA. The stigma and ignorance around mental illness prompted the family to secretly send her off to North Carolina for treatment. When she returned, she was a different person. For all the years that I knew her, she was a total recluse, never leaving home.

My grandmother told great stories and had an infectious laugh that I loved, but I was never fully able to understand her life of tormented isolation until I was hospitalized three times in the mid-1980s. During my last hospitalization, I was kept in seclusion and restrained in my bed. When I returned home I sank into deep despair, overwhelmed by pending divorce, near financial collapse, and a weight gain of some 60 pounds from psychiatric medications. I internalized the stigma and discrimination experienced from mental illness, growing a negative self-image and sense of hopelessness from the prognosis that my life was over as I knew it, and thinking that highly society-valued roles like work may now be too stressful to consider. Like my grandmother, I began to isolate, with suicide becoming an attractive option.

Mounting research shows that people without a social network of support and a sense of meaning and purpose are less resilient against illness—mind and body—and often die younger. That's why meaningful work and peer support are emerging as huge factors in recovery and longevity. But in addition to peer support and gaining meaning and purpose from employment, my self-management really strengthened when I moved into mind-body resiliency. My life was forever changed after hearing a presentation by Dr. Fred Goodwin, former director of the National Institute of Mental Health and a specialist in bipolar illness. His research showed that restful sleep was a huge factor in building resiliency and preventing manic episodes like I had experienced. An anchor for my recovery is managing my sleep and reducing stress by practicing the Relaxation Response made famous by Dr. Herbert Benson at the Benson-Henry Institute for Mind Body Medicine at Massachusetts General Hospital. I was fortunate to have a psychiatrist who fully supported focusing my recovery around managing my sleep and after doing so, changed my medication to help shed much of the weight I had gained.

Today, I live the kind of full and meaningful life that my grandmother was denied, because I was able to receive mental health services with a focus on recovery and learn self-management skills. We have come so far in the fight against stigma, in part because of greater public awareness and education about the nature of mental illness. You heard from another presenter about a program called Mental Health First Aid that teaches a five-step action plan to recognize the signs and symptoms of mental illness, respond to a person in crisis, and encourage seeking professional help, self-help and other support strategies. I am a Mental Health First Aid trainer, which means I teach people how to instruct others in becoming certified Mental Health First Aiders. I have witnessed first-hand the positive impact that comes from people with lived experience of recovery gaining the skills for providing support to help others experience a life of recovery from mental illness and substance abuse. MHFA attendees also learn about the growing awareness of the impact of trauma, especially childhood trauma, on mind-body health and why we need trauma-informed services and supports.

Members of the committee, I urge you to support Mental Health First Aid and other public education programs that help Americans learn how to reach out to their friends and family members who may be experiencing a behavioral health condition. One bill to this effect has already been introduced in the House: The Mental Health First Aid Act (H.R. 274). I encourage you to give this bill a hearing when it is introduced in the Senate and offer your support when it comes before your committee this year.

Next, I would like to share some information about the newest workforce in behavioral health, called certified peer specialists. Peer specialists are trained in skills to promote strength-based recovery and whole health, delivering services that are Medicaid billable when included in State plans. Research on the effectiveness of peers in promoting recovery has been so positive that in 2007 the Centers for Medicare and Medicaid Services (CMS) issued guidelines for States wanting to bill for peer support services, proclaiming them "an evidence-based mental health model of

care which consists of a qualified peer support provider who assists individuals with their recovery from mental illness and substance abuse disorders." [2]

Peer support specialists have personally addressed stigma and discrimination and gained the lived experience to promote recovery and support rather than illness and disability. Because of this, peer specialists are unique in their ability to connect with other peers to ignite hope and teach skills for recovery self-management and promoting whole health. According to a 2008 study by Eiken and Campbell,

> "The growing evidence includes reduced hospitalizations, reduced use of crisis services, improved symptoms, larger social support networks, and improved quality of life, as well as strengthening the recovery of the people providing the services." [3]

Published 2006 research by Davidson ET al., found that

> "peer providers can increase empowerment, decrease substance abuse, reduce days in the hospital, and increase use of outpatient services, at least as long as long as the peer support continues." [4]

A 2006 study by Sells, ET al., found

> "the unique role of trusted peers connecting with each other to foster hope and build on strengths is emerging as a key transformational factor in mental health services." [5]

One of the most innovative services beginning to spring up across the country are peer respite centers. Georgia funds three of these centers and they are proving highly effective at reducing hospitalizations, an important outcome the State has pledged to achieve under a Department of Justice settlement resulting from deaths in State hospitals. In Georgia, if a peer senses early warning signs of possible relapse, he or she can spend up to 7 nights at a respite center supported by peer specialists promoting mind-body health and self-management. Georgia also recently received CMS approval for peer specialists certified in a new training created by the SAMHSA–HRSA Center for Integrated Health Solutions called Whole Health Action Management (WHAM) to bill Medicaid for peer whole health and wellness services.

I urge the committee to support including certified peer specialists as billable providers under Medicaid, given their effective role in supporting their peers in recovery and whole health. However, because Medicaid requires "medical necessity" documenting illness and symptoms and peer specialists are trained to focus on strengths and supports, we need more flexible funding sources to grow the recovery and whole health outcomes peer support services can deliver.

This brings me to the final point I'd like to discuss today: the importance of addressing the mind-body connection when it comes to healthcare.

There can be no health without mental health. Conversely, we cannot successfully care for people with mental health and addiction disorders without addressing their co-occurring physical health disorders. Research indicates that people with severe mental illness in the United States who are served in the public healthcare system have an average life expectancy that is 25 years less than the general public. That's the same as the overall U.S. life expectancy in 1915, a time before any of the healthcare advances that have allowed us to lead steadily longer lives over the last century.

The primary culprits behind this shocking situation are untreated but preventable diseases that commonly occur together with mental illness and addictions: cardiovascular disease, diabetes, complications from smoking and some of the side effects of psychiatric medications that cause weight gain and diabetes. Most people receive routine preventive care that would help identify these conditions early, make lifestyle changes, or receive appropriate medications to ensure they are well-controlled. But people with serious mental illness often cannot access this preventive care—or even get treatment for their other health conditions.

The Substance Abuse and Mental Health Services Administration is working to rectify this problem by providing grants to community behavioral health centers for offering basic primary care screenings and coordinating referrals to primary care.

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[2] Center for Medicare and Medicaid Services, State Medicaid Director Letter #07–011. August 15, 2007.

[3] Eiken, S., & Campbell, J. (2008). Medicaid coverage of peer support for people with mental illness: Available research and State example. Published by Thomson Reuters Healthcare. Retrieved from: *http://cms.hhs.gov/PromisingPractices/downloads/PeerSupport.pdf*.

[4] Davidson, L., Chinman, M., Sells, D., & Rowe, M. (2006). Peer supports among adults with serious mental illness: A report from the field. *Schizophrenia Bulletin*, 32, 443–450.

[5] Sells, D., Davidson, L., Jewell, C., Faizer, P., & Rowe, M. (2006). The treatment relationship in peer-based and regular case management services for clients with severe mental illnesses. *Psychiatric Services*, 57(8): 1179–84.

As part of the Primary Care-Behavioral Health Integration program (PBHCI), nurses, trained care managers, peer specialists, and other types of healthcare professionals are now actively working in 94 grantee sites to screen patients for weight gain, blood lipid levels, cholesterol, and more.

Although data is still being collected, early results indicate that this program has been successful in helping people with behavioral health conditions maintain or reduce their weight, cholesterol, blood sugar, and other risk factors for chronic disease. I strongly urge the committee to support this important grant program.

In closing, I would like to say that nearly three decades of experience in behavioral health has taught me that the greatest potential for promoting recovery and whole health comes from within an individual, with the support of peers, family and community. My recommendation is to establish and support programs that drive this potential, putting the person at the center of all services, building on their strengths and supports.

The CHAIRMAN. Well, thank you, Mr. Fricks. I think your testimony really does kind of summarize what we're all here about today, and that is providing the kind of interventions and early support so that people can successfully deal with an illness, just like we deal with every other illness, and you're a prime example of that. From my limited experience in this area, I couldn't agree with you more that the most important element in this comes from within, and how do we build that system.

Peer support is so important. You talked about maybe billable hours for providers of peer support. I can tell you that it is so extremely important that self-management skills need to be taught. A lot of times, this doesn't come from just a drug. I think it also recognizes—and I'll get back to Dr. Vero on this also—that mental health and physical health are, as you said, intricately intertwined, intricately intertwined.

Now, again, at the risk of practicing medicine without a license—but I've been involved in this for almost 30 years now from this standpoint in this committee and my other committee—I think we have more than adequate data to show that so many physiological conditions have their genesis in psychological conditions. And yet we always attempt to just treat the psychological condition, and sometimes that makes it even worse.

We had a hearing on this last year on pain and all the pain clinics that have come up all over America. They're treating pain. Yet we had one witness, a very distinguished doctor who had written a lot of books about this—not everything, you can't make everything just total. But the vast majority of these pain afflictions has its genesis within psychological problems, anxiety, stress, things like that that manifest themselves in pain.

Yet people go to pain clinics to get a shot or to get some kind of medicine or to get a back operation or something like that that may not be warranted. Again, I'm always cautious to say that it's not 100 percent. I'm just saying that the vast majority of this—I just don't think we recognize that, this intricate intertwine between mental health and physical health.

Well, I took a lot of my time talking, and I shouldn't. But I want to start with Dr. Hogan.

You talked about getting it right—primary care providers providing mental healthcare, moving from a separate system. Tell me about the accountable care organizations that are springing up. They're going to have the guidelines, you say, for what these enti-

ties have to provide. But I don't think we have any kind of instructions to them.

Is that what you're suggesting, that we need to instruct these accountable care organizations that they also need to structure this? They need to structure it?

Mr. HOGAN. Absolutely. They'll learn this sooner or later.

The CHAIRMAN. Well, we can't wait until later.

Mr. HOGAN. Exactly. So, for example, if you have diabetes or hypertension or cancer or these other major medical problems, and you also have depression, your total medical costs are going to go up somewhere between 50 and 75 percent. And if you treat the depression, it allows the person, as Larry was saying, to be an active player in the management of their whole health.

But you can't hope that their depression goes away. You actually have to diagnose it. You have to provide a little treatment for it. But the data shows that a relatively small investment in providing that mental healthcare in that primary care setting—or it might be in the context of an ACO—is going to reduce total cost because people are going to be better able to take care of themselves.

The CHAIRMAN. Dr. Vero, you mentioned that also in your testimony about the accountable care organizations. Do you have any elaboration on what Dr. Hogan just said?

Mr. VERO. I think the other element at play would be our expectations for accountability, so let's underscore that. That act will allow us to set some clear expectations for performance, what is expected in terms of improving those healthcare outcomes in the agreement between those accountable care organizations and the provider in that provider system. We are now beginning to target what are those key healthcare indicators on the physical health side, on the behavioral health side, that will work together to truly improve overall outcomes.

The CHAIRMAN. There's a barrier of insurance coverage. I think you mentioned that. In this area around Washington, DC, there are very few in-network mental health providers. I started looking at that some time ago and wondering why. I have good coverage, Blue Cross Blue Shield, all that. But I'm amazed at how few are in the network.

The more I looked at it, they said, "Well, the reimbursement is not good enough." Well, I looked at that a little bit longer, and then I started thinking and looking at the amount of support that taxpayers through Federal programs and other programs gave these practitioners when they were going through medical school, or when they were then going into their specialties, and then when they were going into their residencies.

To be sure, a lot of them accumulated a lot of debt themselves that they're paying back. But, again, they got these nice guaranteed government loans at low interest rates. So I'm just wondering shouldn't we expect a little more of them than that they just don't get reimbursed enough by Blue Cross Blue Shield so they're out of the network?

As I think Senator Sanders said, if you have the money and you can afford it, you're fine. But you could be actually paying a lot in your insurance coverage, still not having the coverage for mental

health services, and then you've got to pay additional out-of-pocket for that. Any thoughts on that?

Mr. DelGrosso.

Mr. DELGROSSO. Yes, sir. Thank you so much for making that comment, because it's something that's, like they say, the proverbial elephant that's in the room that people don't often talk about. And it's been sort of surprising to me how insurance companies have not been able to somehow put together the savings on the physical health side if they provide more care on the behavioral health side.

It may be due to the fact that they have short-term contracts and don't necessarily look at the long run with it or whatever. But I think that what we see is the head is not connected to the body and sometimes often is the management and the thinking as people go forward. So they look at the physical health costs separately from the behavioral health costs.

One of the real pluses for accountable care organizations that you were talking about is the opportunity to bring together the funding to put the right service, the right place, the right time, and the right cost or right payment that might be there. And it brings all four of those pieces together, where if you're saving money on the physical health side by providing more behavioral health services, you can move that money over there as needed and vice versa. So it's really important.

I think the expectation of providing care for people who are uninsured has fallen greatly on the Federal Government and on our States in their indigent care programs and then their Medicaid program. So people end up shifting over to the public side because they don't have the behavioral health coverage on the physical health side. It's a quagmire, but I think that we're on the verge of making some changes that could be very helpful for us.

The CHAIRMAN. I just told my staff what you said. We've got to work on this. We've got to make sure these accountable care organizations have that model and that they fully implement that model. And, hopefully, we can, through this committee and through the Administration and others, impress upon them the necessity of doing so.

Well, thank you. I've run way, way over my time, and I apologize.

Senator Alexander.

Senator ALEXANDER. That was very interesting. Thank you, Mr. Chairman.

Well, thanks to the four of you for coming today. I'd like to listen to what you have to say, so I'll ask a question and then I'll ask each of you to answer. If you could think of one thing that the Federal Government could do, that we could do, to make it easier for you to spend the money we now spend more effectively—the money we spend primarily through the two big block grants and through Medicaid is the way I gather that most of the Federal money goes to mental health. What would be the one thing that we could do that might make it easier for you to do that?

Dr. Vero, if you could start—and I'd like to ask you this additional question. You mentioned about the importance of a continuum, which makes sense, for a community mental health center.

Now, you're one of the largest operators of community mental health centers. Would that be an additional cost to each community mental health center if it did that? If so, who would pay for that?

If the Federal Government were to require that, how much would it cost and how much money would we have to appropriate for that? Or if we require it without paying for it, which is sometimes what we do around here, then who would pay for it?

Mr. VERO. Senator, I want to first start with an acknowledgement of my early service in Tennessee and you in your Governor role. We talk about this continuum of care over the age span. When you were Governor of Tennessee, we built out a statewide therapeutic preschool program. We had therapeutic preschools in every single one of our community mental health centers across all 95 counties.

Those schools were there to deal with their most vulnerable children with whom we were seeing early indications of the onset of severe mental illnesses, those SED children we've referenced several times today. So what happened? Very few of those programs exist. And I can tell you we are so fortunate at Centerstone to still continue that program. But it's not in the four-wall classroom any longer because that model was no longer affordable.

Community mental healthcare has been subjected to a horrid state of commoditization. It's just a fact. As we move from Medicaid programs to managed Medicaid programs, we are part of the healthcare system that continues to be looked at as a commodity. Our services are minimized oftentimes to their smallest view, to the nickel—you know, to the dollar, to the quarter, to the nickel for differences in choosing who the provider might be, where the contract is, or, more importantly, what the service is, what that array of services are.

As that requirement dropped with that commoditization, those preschool programs were lost. We took our preschool program and moved it into the community. And here's the good news. We were only able to serve about 48 of those children a year, because it was a high-cost program and because the managed care company had a hard time understanding what its role was in addressing the healthcare needs of these children while they were also receiving vital educational services.

One of the things we need to do from that Federal level is let's remove these barriers that oftentimes don't allow us to bring our systems together—education, criminal justice, mental health—in a cooperative way for the sole purpose of addressing our healthcare crisis. We spend too long arguing over what part of the day education should pay for versus what part of the day a managed care company or Medicaid should be paying for. We have to address those conversations immediately if we're going to make any difference in the conversation that we're having.

Senator ALEXANDER. Well, I'd like to work with you, and I'll ask my staff to followup to get specific examples of how to do that. Just out of curiosity, was that part of the Healthy Children Initiative that we had in Tennessee back then?

Mr. VERO. Initially, yes, sir.

Senator ALEXANDER. Well, I'll tell my wife. That was 30 years ago. My wife was the head of that, and the deputy of that was Mar-

guerite Sallee, who ran America's Promise until recently and headed Bright Horizons, the worksite daycare company.

Now, my time is about up. But if there's one thing that we could do that would change existing law or practice to spend the money we now spend better—and you can follow that up in writing if you'd like to—is there one thing you'd like to briefly mention? And that's my last question.

Mr. DELGROSSO. I'd like to make a recommendation that you allow that the services that you currently pay for be opened up to provide more services at the front end, to provide more prevention, early intervention, support peer services like what Larry was talking about a little while ago, and to let the creativity of this country and how we're moving forward in other areas of healthcare to also enter into behavioral healthcare and allow us to do the right thing.

Senator ALEXANDER. Was there any other comment on that?

Mr. VERO. Senator, if I could add to that, we keep talking about access. We've talked about the shortage of psychiatrists, especially child and adolescent psychiatrists. We've been providing telepsychiatry services since 2002 in the State of Tennessee. Those services are getting out to counties where we can't hire physicians, where we can't draw those physicians to maybe those more rural areas.

It is 2014 as we sit here today. We need to align our payment streams with our current technology. We're not permitted in the State of Tennessee—and I know elsewhere throughout the country—to provide telecounseling services. I can have a psychiatrist talk to a child and interview that child and provide services and work alongside a practitioner who's sitting next to a child and do medication management. But I can't provide counseling services remotely through telehealth and get reimbursed.

It's 2014. We have 12 years of experience on the psychiatry side, and we can't seem to move out of the current limitations around those services.

Senator ALEXANDER. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Alexander.

Senator Franken.

Senator FRANKEN. Thank you, Mr. Chairman.

Thank you all for your testimony.

Dr. Vero, you note in your written testimony that there are a number of barriers to access to children's mental health services. Specifically, you recommend,

> "grant funding streams that encourage existing centers to expand their service continuum and partner with community organizations."

I mentioned in earlier questioning that I'm introducing a bill called The Mental Health in Schools Act, which does that exactly by providing grant funds for schools to partner with mental health centers and other community-based organizations. Can you explain why this is so important to students?

Mr. VERO. Senator, first, let me thank you for moving that bill forward again this year. I think it's rather simple. We know that most of the disorders that we see in children are first identified, not, as most of us would believe, in the office of a pediatrician or their family practitioner, but instead by their school teachers, some as early as their preschool teachers who see this behavior.

They're well-trained in normal child development. They typically know what is expected of that age group. When they see unusual and bizarre behaviors or very, very troubled children, they need to bring that to the attention of professionals. Your bill is encouraging the same thing. Those teachers have the competencies to help us identify those children who need early intervention.

We're in 160 schools currently in Tennessee. Those are partnerships that work. I have licensed master's level therapists in those schools providing the care that you're outlining, that you're addressing. We need to get school-based services throughout the country.

Senator FRANKEN. I was just in Mounds View, MN. We had a roundtable there—a couple of roundtables, but one specifically on integrating community mental health. And you talk in your testimony also about how this is really a family disease or a family matter.

We had three mothers talk, whose kids were turned around completely because the school system had integrated their system with community health, and they had a mental health partner, a professional who took their caseload of a number of children. We had one woman there—I think she was 26. She had an 8-year-old child who had been completely turned around. She was a single mom. She was not a wealthy woman living on Fifth Avenue.

This woman had such a joy in describing her son who had been completely turned around. He was diagnosed, I think, with Asperger's, and he had been unruly. But once they got ahold of it, he's turned around completely. And we had two other moms there. This is a family disease.

Mr. VERO. It is.

Senator FRANKEN. I wrote two movies like 20 years ago on the family disease of alcoholism.

Thank you, Mr. Fricks, for your testimony. Congratulations on 28 years of sobriety.

When I was doing research for that, I was talking a lot to rehab counselors.

Dr. Hogan, I want to ask you about this—the shocking ignorance of general practitioners about alcoholism. The teacher is for kids in the school. But the pediatricians—what they don't know about this is pretty remarkable. Integrated care is so important, and it's something we do pretty well in Minnesota. We have accountable care organizations that were already accountable care organizations before we wrote accountable care organizations into ACA, and they've become pioneer ACOs.

What can you say about the training of doctors in medical school that we should be doing that we're not doing? Or have we gotten better at that?

Mr. HOGAN. Thank you, Senator. I want to just comment very briefly on your point about children and to underline this in a way that I think may resonate with Senator Harkin, because he's been closely connected to and has followed and help build an extraordinary national program of early intervention for young people who have got a developmental disability. If you have a significant developmental disability, you're basically entitled to some support and care for yourself and your family.

For children with these problems that you're describing and that 8-year-old you described who got turned around, we have an average wait of 9 years until we find out about it. And these are conditions where just a little bit of help is going to change that young man's trajectory possibly for the rest of his life. So this is of profound importance.

I'll say two things with respect to your question around doctors and their training. One is that training around these conditions is—there's too much that they have to cover in medical school, and this gets short shrift, period. But it's not a problem that can be fixed by training doctors better, because the primary care doctor has 7, 8, or 10 minutes.

The only way that this integrated care can be delivered is if one of our types is basically parachuted into that doctor's practice. And if the patient does a screen in the waiting room, the doctor can then say, "I see you have concerns about your sleeping and you're feeling depressed, and I'd like to ask Ms. Jones to come in. She's an expert in that area." Ms. Jones can then spend the time that it takes to talk through the symptoms, to maybe explain the sleep issue that Larry described.

These programs that go under a rubric of collaborative care—the doctor does have to change behavior a little bit, but it's got to be a team approach, and the team approach can be thwarted by two things. One is if we take the mental health benefit—I'm going to argue in a way that may seem reverse. If we keep the mental health benefit in a separate insurance plan and only pay it to mental health specialists, it's not going to help the primary care doctor.

But if we give it to the mainstream insurance plan and don't make them measure it—did you ask about depression, did you start people on treatment, did they improve? Unless we do that, we can't expect results either. So we're sort of getting what we have designed. I'm going to say that parity, as important as it is, is, I think, less critical now than figuring out how to crack this problem of primary care and getting support to the doctors out there that have got 8 minutes, don't have the training, and don't know how to do this stuff.

Senator FRANKEN. I would just argue that when these conditions, the mental health conditions, these addiction conditions somatize themselves into other things—I see a lot of nodding—that there are primary care physicians who don't understand that and don't understand that they're seeing something that really comes from something else, something else that may be addiction or may be mental health.

I'm way over my time. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Franken.

Senator Warren.

Senator WARREN. Thank you, Mr. Chairman.

Thank you all for being here today. I read your testimony, all of it. It was very powerful testimony. Thank you very much.

The thing I drew out of the testimony, though, is a part we haven't talked about, and that is that millions of people who have serious mental health issues are not seeking care. And you've talked in different ways about why that is so. You're all kind of de-

scribing a different part of the animal. Mr. Fricks talks about stigma and why people don't ask for care.

We talked about the availability of treatment, practitioners, whether or not we've got enough people, how we might deal with that with peer specialists, how we might deal with that with community healthcare centers and doctors' offices. We talked a little bit in the earlier panel about research, the importance of research, so we get better treatment, how we get better outcomes at lower cost.

But the one I wanted to focus on in this last opportunity to talk is about the cost to the individual. I saw in the Kaiser study that 45 percent of those who don't seek care indicate that the cost is what deters them, that all those other things are there but they feel like they can't afford it, that they can't go out of pocket.

What I'd like to hear from you is about the impact, about what that means when people deny care to themselves, to their children, to spouses and others in their families, and just what happens then. And to describe that either—we can talk about it in human terms and we can talk about it in financial terms, and in financial terms for the family or for the whole system. So I'd be grateful if you'd talk about that.

Maybe, Mr. Fricks, you'd like to start.

Mr. FRICKS. Well, in rural communities like mine, it's so obvious about the stigma, because you'll park out front if you go into the public health, but if you've got to go to mental health, you try to park around back. You don't want your neighbors seeing you going into community mental health. So when we integrate, we'll help fix that. Everybody can go through the same door and park in the same parking lot.

But it's hard to explain the devastation that occurs from the stigma and the active discrimination. It goes beyond just stigma. Of all the disability groups, we're the least employed in the country. It bumps 90 percent. And, by the way, employment is a huge factor in our recovery when people have meaningful work. In housing, we're discriminated against.

A lot of it is—it's almost a civil rights issue. It's a human rights issue. I am hopeful that integration helps that. And then families are really torn apart by it, too. I'm very fortunate to have had a very supportive family. But the stress and strain economically will bust up marriages. It's just a fact. I mean, you're right on it. So thanks for your acknowledgement of that.

Senator WARREN. Thank you.

Mr. DelGrosso.

Mr. DELGROSSO. Larry, thanks. You say it so well. I just think it's interesting that families would not hesitate to get a family member help for appendicitis or any other kind of physical health problem that they have, but often have a very difficult time reaching out to get the behavioral health and the substance abuse disorder treatment that they need.

The bottom line is that it's often seen as that you have a character problem, or you've got a bad mom and dad, or something along those lines, rather than the fact that for many people, they have a brain disease. There's a lot of education yet still to come and a lot of support that we need at several levels for people to be

able to move forward and raise their hand to come out and get help.

I can also say as a mental health provider all these years that we need to stick our head up a little bit, too, and be proud of the fact or the area of healthcare that we provide care in and that we're not an enigma. Let's take the cloak off of this and let's talk about what it really is and how people can recover and become remarkable members of our community.

Senator WARREN. With the Chairman's indulgence, could I ask you, Dr. Vero, to add your comments briefly, and Dr. Hogan?

Mr. VERO. Senator, thank you for the question, and I'll answer it, I think, from maybe both the human side and the financial side. We can't afford not to treat these illnesses that we identify, especially those that we identify early. They simply get worse. Mental illness is a systemic family disease. We know that when we look at addiction disorders, in particular, alcohol. There may be one individual in that family with an alcohol addiction. That entire family can pick up signs and symptoms of that illness, and there's dysfunction throughout that family.

Those same things often occur with people who have severe and persistent mental illness. Mental illness is the leading cause of disability in the United States. That cost alone should alarm us all, and we have to start treating this on the front end and not treating it with disability payments.

Senator WARREN. Thank you.

Dr. Hogan.

Mr. HOGAN. I'll conclude on that same point. At some point within the last 10 years, the total cost to society of mental illness passed the total cost of cancer and is running second to heart disease. But what is striking about those statistics is that while the cost of cancer and heart disease is the cost of providing care, the cost of mental illness is essentially the cost of not providing care.

It's the cost of years lost of life due to suicide, of people not being able to function fully at work, of children not graduating because they weren't able to sit in their seat long enough, and then it escalated, and then they dropped out in high school. So if we could reverse this just a little bit and provide effective treatments, maybe we could slip back from No. 2 to No. 3 again.

Senator WARREN. Thank you very much.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Warren.

I just want to thank this panel very much, both for the work you do and for the testimony you've offered here today. Again, the reason why we wanted to start off this Congress and why I wanted to start off this Congress with this kind of hearing in this committee was simply for the reasons that many of you expressed in one way or the other. And that is, we can't really get a handle on a healthcare system in America until we get a handle on integrating mental health with physical health. And I would lean a little bit more toward Mr. Fricks' side on looking at this mind-body connection.

Dr. Hogan, I appreciate that not every primary care practitioner—they've only got 8, 9, or 10 minutes. They've got to remember a lot of stuff from medical school and their residency training.

But it does seem to me that a system ought to be built where you have a collaboration. I have seen these. They're around the country, where if you go in, and you have, hopefully, electronic records, and you have some ailment that you've come in to see a primary care practitioner about, whether it's in a community health center or someplace else, a private practice, that there's a collaboration with the primary care physician and maybe a physical therapist, a psychiatrist or psychologist or maybe both, to take a look at what really is affecting this person.

Is it a physical ailment that requires some physical intervention, or is it a physical ailment that's been manifested because of a psychological problem that needs to be attended to, or is it something else? Is this something where a qualified therapist could work with them and their family rather than thinking there has to be some prescription for some medicine filled out that they go to the drugstore to get?

It just seems to me that as we're moving ahead with this Affordable Care Act and this new regime with all the exchanges and everything, we have an opportunity, I hope—and with the expansion of the community health centers around America, and that's where Dr. Vero—we're going to be in touch with you more about what you've done in Tennessee, because I think there's a model there for what we're going to do with community health centers in the future and how they're integrated into the system.

That's why I think this hearing is so important, because you, Dr. Hogan, just said that the cost of mental illness now outstripped the cost of cancer in our country, and yet we just don't pay attention to it. Hopefully, this will set the stage for a lot of good bipartisan work and integration here of this committee looking at what we need to do to provide this sort of new integrated model in this new healthcare regime that we seem to be embarked upon here sometime in the near future.

I thank you very much. I am certain our staffs or us will be in touch with you as we move along here for further enlightenment and further suggestions and recommendations that you might have.

Senator Alexander.

Senator ALEXANDER. I want to thank Senator Harkin for this, and I want to thank the witnesses for coming. You made some very useful suggestions, and I look forward to following up. If I may say it this way, this is a committee on which we can have some fairly profound differences of opinion when we're talking about new laws, new spending, new policies.

But it seems to me that a lot of what we fail to do here in the Federal Government is look at what we're already doing and ask the people who are doing it how we can take the programs and the money that we have and make it easier for you to do what you need to do. You've given us a long list of things today that you have suggested that would improve your ability to identify who needs help and identify the person to provide the help.

While we may argue about some things, there's no need to argue about those things. We can work together on those things, and I would look forward very much to that opportunity, and I'll forward to your specific suggestions about the laws, regulations, and prac-

tices that you think we ought to change. And I'll work with Senator Harkin and see if we can do this in a bipartisan way.

The CHAIRMAN. Thank you very much, Senator Alexander.

I request that the record remain open for 10 days for members to submit statements and submit additional questions for the record.

With that, thank you all very much. The committee will stand adjourned.

[Additional material follows.]

## ADDITIONAL MATERIAL

## PREPARED STATEMENT OF SENATOR CASEY

Chairman Harkin, Ranking Member Alexander, I would like to thank you for convening this timely hearing to assess the state of our Nation's mental health system. It is unfortunate that it takes a tragedy on the scale of Sandy Hook, Tucson, Aurora or Virginia Tech to refocus our attention on the need for better access to mental health services, when one in four adults will suffer from a diagnosable mental illness in a given year and only 60 percent of people with serious mental illnesses get access to the mental health care they need.

We have made progress in the last few years: we passed the mental health parity law, requiring health insurers to cover mental health benefits at the same level as other medical benefits; we have improved the supports available to our veterans suffering from post-traumatic stress disorder as a result of a decade of conflict and repeated deployments; and we passed the Affordable Care Act, which will increase access to all health services, including mental health services.

Yet the repeated tragedies linked to individuals with serious mental illnesses, in addition to the countless individual tragedies that don't make the news because they are all too common, indicate that we must do more. Millions of people across the Nation are facing mental illness every day, and are not getting the help they need. In Pennsylvania, there were 1,547 suicides in 2010, the most recent year for which data are available; that works out to approximately four suicides per day (data from the Pennsylvania Department of Health).

We also need to address the stigma that still surrounds mental illness. No person should ever be afraid to seek medical treatment, including mental health treatment. We all have a role to play in educating ourselves and our communities about mental illness. Only by being accepting and honest about the devastating effect of mental illness can we encourage the people bearing this burden to come out of the shadows and seek the help they so desperately need.

I am pleased that President Obama recently committed to finalizing the mental health parity regulations and the regulations on the essential health benefits and parity requirements within the health insurance marketplaces under the Affordable Care Act.

Again, I would like to thank Chairman Harkin and Ranking Member Alexander for convening this hearing, and would also like to recognize Chairman Harkin for his dedication to this issue over many years. I look forward to hearing from our witnesses today, and to working with my colleagues on the committee and in the Senate to improve our Nation's mental health system.

## RESPONSE BY PAMELA HYDE, J.D. TO QUESTIONS OF SENATOR ALEXANDER, SENATOR MIKULSKI, SENATOR MURRAY, SENATOR CASEY, SENATOR BENNET, AND SENATOR ENZI

### SENATOR ALEXANDER

*Question 1.* How have you worked with States and other stakeholders to ensure that grants and cooperative agreements administered by SAMHSA have been re-

sponsive to the needs of local communities and States? What are some things that can be done to make things easier for States?

Answer 1. For all SAMHSA grant programs, States and communities are asked to identify the specific need in their local jurisdiction and describe how the grant funds would address that need. This is done intentionally in order to allow States and communities to prioritize funds based on their specific needs.

SAMHSA also provides technical assistance (TA) to communities and States to ensure their needs are met and that the most effective and efficient services are being developed. SAMHSA provides TA not only to its grantees for the implementation of specific grant programs but also to States and communities for larger system-wide change and enhancement.

*Question 2*. It is my understanding that you are making revisions to the Community Mental Health Services Block Grant Application and the Substance Abuse Prevention and Treatment (SAPT) Block Grant Application, and one of the proposed changes is to move the deadline to April 1 for the applications from the statutory requirement of September 1 for the Mental Health Block Grant and October 1 for the Substance Abuse Block Grant.

Can you give me a status of the pending application and how you are working with States to give them flexibility to submit the application given the statutory deadlines of September 1 and October 1, and the final applications not having been released?

Answer 2. The fiscal year 2014–15 Uniform Application which is used for the Mental Health Block Grant (MHBG) and the Substance Abuse Block Grant (SABG) was published in the Federal Register. We expect the Application to be finalized later this year. SAMHSA has communicated to the block grant jurisdictions that the statutory deadlines remain the same (September 1st for the MHBG and October 1st for the SABG), but has encouraged an earlier submission date to allow for the States and SAMHSA to enter into a meaningful discussion of the State plan at a time when it can still be modified.

*Question 3*. Patients and providers alike in rural areas face particular challenges with respect to access. What has SAMHSA been doing to work with States to improve access in these areas?

Answer 3. SAMHSA's Block Grants provide flexible funds that States can use to provide access to necessary services, including services in rural areas. As a component of the application for Block Grant funds, States provide an assessment of their strengths and needs of the service system and identify unmet service needs and critical gaps.

In addition, SAMHSA's Grants to Expand Care Coordination through the Use of Health Information Technology in Targeted Areas of Need (Short Title: TCE–Health IT) leverages technology to enhance and/or expand the capacity of substance abuse treatment providers to serve persons in treatment who have been underserved because of the lack of access to treatment in their immediate community. The lack of access may be due to transportation concerns, a limited number of substance abuse treatment providers in their community, and/or financial constraints. The use of health information technology (HIT), including web-based services, smart phones, and behavioral health electronic applications (e-apps) expand and/or enhance the ability of providers to effectively communicate with persons in treatment and to track and manage their health to ensure treatment and services are available where and when needed. Grantees use technology that will support recovery and resiliency efforts and promote wellness.

In addition, HHS has been a key participant in the White House Rural Council, which was created in June 2011 through an Executive order. The Council is a combined effort of the White House Domestic Policy Council and the National Economic Council, with the Secretary of Agriculture serving as chair and Cabinet Agency heads serving as members. The Council works across executive departments, agencies, and offices to coordinate development of policy recommendations to promote economic prosperity and quality of life in rural America.

*Question 4*. The Centers for Disease Control and Prevention (CDC) has classified prescription drug abuse an epidemic in the United States. In 2011, 2.4 million new individuals began using prescription drugs for nonmedical purposes. The widespread nonmedical use of prescription drugs has increased the numbers of overdose deaths and hospitalizations. In 2008, the CDC found that prescription drug misuse and abuse had caused 20,044 deaths and over 1,345,645 emergency room visits. In Tennessee, prescription drug abuse is a major problem. Can you tell me what role SAMHSA is playing to address prescription drug abuse?

Answer 4. SAMHSA works across the Department of Health and Human Services through the Behavioral Health Coordinating Council's (BHCC) Prescription Drug Abuse Committee. As a result, SAMHSA has partnerships with CDC, Food and Drug Administration (FDA), National Institutes of Health, Centers for Medicare & Medicaid Services, the Office of the National Coordinator for Health Information Technology (ONC), and the Office of the Assistant Secretary for Health aimed at preventing and treating prescription drug misuse and abuse. SAMHSA is represented on the Office of National Drug Control Policy Interagency Workgroup on Prescription Drugs. SAMHSA's strategy to reduce prescription drug abuse and assist individuals who misuse or abuse prescription drugs is in alignment with the Office of National Drug Control Policy's four-part strategy: education for prescribers and the public; prescription monitoring; safe drug disposal; and effective enforcement. SAMHSA's contract supporting the Annual National Survey on Drug Use and Health is an integral part of our national surveillance of non-medical use of prescription drugs.

*Education*—Current prescribers—SAMHSA has supported the education of prescribers for the past several years through formal continuing medical education courses and other less formal efforts, *e.g.*, webinars hosted by SAMHSA's opioid prescriber clinical support system (PCSS) grantee (American Academy of Addiction Psychiatry). SAMHSA has placed a priority for these prescribing courses in States with the highest rates of opioid-related mortality—*e.g.*, New Mexico and West Virginia. SAMHSA is also a participant in the NIH Pain Consortium.

Future prescription drug prescribers—SAMHSA's SBIRT (Screening, Brief Intervention, Referral to Treatment) program is an important tool for early identification of persons who might be at risk for opioid dependency. SAMHSA's SBIRT Residency grant program addresses future prescribers and includes screening for prescription drug abuse, and more recently has emphasized the use of State prescription drug monitoring programs (PDMPs).

*Prescription monitoring*—In 2012, SAMHSA developed a grant program, in partnership with ONC and CDC to allow States to increase their ability, with appropriate privacy protections, to link PDMPs with other electronic health care record systems (physicians' offices, pharmacists, hospital emergency departments, and Health Information Exchanges). In addition, the grants will be used by States to connect their PDMPs to other States to improve interoperability.

SAMHSA has also partnered with ONC to fund pilots that test secure linkages between PDMPs and EHR systems across multiple facilities. Some of these pilot programs are also exploring ways to incorporate real-time PDMP data at points-of-care and dispensing, further streamlining these data checks for standard patient care. Finally, SAMHSA staff is participating in projects with other agencies to increase the ability of PDMPs to identify outbreaks of prescription drug abuse.

*Prevention of Prescription Drug Abuse in the Workplace* (*PAW*) *Technical Assistance Contract*—The PAW program provides technical assistance to help local, government and military workplace and communities understand the prescription drug abuse problem and reduce related problems by stimulating, informing, and supporting employer- and community-based prevention/early intervention efforts. The PAW educational and technical assistance efforts and resources focus on SAMHSA grantees; employers, unions, and other communities; and collaborate with partner organizations. PAW educational/technical assistance resources include fact sheets, web products, assessment tools, presentations, trainings, and literature reviews. Topics such as developing specific workplace prescription drug abuse policies; integrating prescription abuse messaging into current programs and community outreach activities; and prescription drug abuse evaluation activities and metrics are addressed.

*Prescription Drug Abuse Treatment*—Treatment of opioid dependence/addiction is a critical element of SAMHSA's strategy and includes expanding and improving access to the three FDA-approved medical treatments: methadone (regulated by FDA, SAMHSA, and the DEA), buprenorphine (SAMHSA works together with the DEA to process waivers to enable physicians to prescribe buprenorphine products), and naltrexone, both oral and extended release products. SAMHSA has been working with other Federal agencies to explore "telemedicine" enabling treatment in rural settings. SAMHSA is continuously educating providers and consumers about these medical treatments through educational efforts, the PCSS model referenced above and interactions with the provider communities. SAMHSA works with the FDA to ensure that safety of these medications is continuously monitored and analyzed. For example, SAMHSA convened expert panels and work groups with the FDA to assess the safety of methadone in terms of cardiac health; methadone-related mortality associated with overdose; buprenorphine and risk of pediatric exposure; and diversion of these medications for illicit or inappropriate use. SAMHSA convened a similar

meeting on developing guidelines for the medicine Vivitrol, an injectable medicine designed to treat opioid dependence for up to 30 days.

SENATOR MIKULSKI

*Question 1*. I am a big champion of privacy but with Virginia Tech, none of the systems talked with each other. How can we make sure privacy is protected and everyone in the system is talking to each other when problems arise?

Answer 1. SAMHSA agrees that it is critical that privacy be protected in behavioral health treatment. However, SAMHSA recognizes that there are situations and crises that require the sharing of information about an individual to other clinicians, to the judiciary, to law enforcement or to the National Instant Criminal Background Check System (NICS). This balancing of competing interests is essential for the health of the individual who presents for behavioral health care and for the well-being of society should an individual suffering from a behavioral health illness be a threat to themselves or to others.

On January 16, 2013, President Obama implemented 23 Executive Actions to reduce gun violence. Following the release of the President's plan, the HHS Office for Civil Rights released a letter to the provider community and other interested parties clarifying that the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule does not prevent the necessary disclosure of critical information about a patient to law enforcement, family members of the patient, or to other persons, when the provider believes that patient presents a serious danger to himself or to other people.

Some States have cited concerns about restrictions under HIPAA as a reason not to share relevant information on people prohibited from gun ownership for mental health reasons. The Administration will begin the regulatory process to remove any needless barriers, starting by gathering information about the scope and extent of the problem.

In addition to what HIPAA permits in terms of disclosure, most States have laws or court decisions which address, and in many instances require, the disclosure of patient information to prevent or lessen the risk of harm. Since the classic ruling of *Tarasoff* v. *Regents of the University of California* (1976), mental health professionals in many States have had a legal duty to protect intended victims by notifying them and the police of threats of harm. In the years since *Tarasoff*, mental health professionals have generally adopted some version of the duty to protect reasonably identifiable third parties as a standard of practice. Most behavioral health providers are aware of the duty to protect third parties; however, most primary care providers are not covered by the *Tarasoff* principles.

Subsequent to the Virginia Tech shootings, the Virginia Tech Review Panel found that the University believed that communicating their concerns about a student with one another or the student's parents was prohibited by the Federal laws governing the privacy of health and education records. In reality, Federal laws and their State counterparts afford ample leeway to share information in potentially dangerous situations.

Furthermore, in the Virginia Tech shooting, the student purchased two guns in violation of existing Federal law. The fact that in 2005 he had been judged to be a danger to himself made him ineligible to purchase a gun under Federal law. The Virginia Tech Review Panel found that there was a lack of understanding about what information could be shared and by whom. Under the President's gun violence reduction plan announced in January, the Department of Justice will invest $20 million in fiscal year 2013 to give States stronger incentives to make relevant information—including information on persons prohibited from possessing firearms for mental health reasons—available to the background check system. The Administration is also proposing $50 million for this purpose in fiscal year 2014, and will look for additional ways to ensure that States are doing their part to provide relevant information.

One of SAMHSA's top Strategic Initiatives is health information technology. SAMHSA is working closely with the Office of the National Coordinator for Health Information Technology to encourage States and providers to implement certified electronic health records and to promote the exchange of health information using recognized standards. One of SAMHSA's main HIT goals is to ensure the secure exchange of electronic behavioral health information while protecting the privacy rights of individuals.

Health information exchanges (HIEs) are quickly integrating into the healthcare landscape enabling real-time access to patient health information from multiple sources. SAMHSA is collaborating with other agencies (*e.g.*, veterans agencies, criminal justice, and housing) to develop a plan to securely exchange relevant health

information while complying with Federal and State privacy and confidentiality laws.

SAMHSA believes that the strategies mentioned above will go a long way in making sure that privacy is protected while permitting everyone in the system to "talk to" each other when problems arise.

*Question 2*. What is SAMHSA doing with the Department of Defense to prevent suicide across the services and for our veterans?

Answer 2. SAMHSA has been working with the Department of Defense (DOD) on preventing suicide since at least 2000, during the development of the first National Strategy for Suicide Prevention (published in 2001 and revised in 2012). With a strong respect for the respective areas of expertise in military culture, medicine, behavioral health, and evidence-based practices, the Agency and Department work together on a variety of fronts and in a range of initiatives.

In 2005, the DOD joined the Federal Partners Working Group on Suicide Prevention, a mechanism for Federal agencies to increase collaboration and coordination in their suicide prevention policies and initiatives. DOD and SAMHSA co-chaired the Working Group between 2005 and 2010, and the acting director of the Defense Suicide Prevention Office (DSPO) continues to participate in the Group's monthly calls.

In 2009, Dr. Richard McKeon, Chief of SAMHSA's Suicide Prevention Branch, was selected by then Defense Secretary Gates to be one of seven civilian members of the DOD Task Force on the Prevention of Suicide by Members of the Armed Forces. Among the recommendations of the Task Force was the establishment of a DOD suicide prevention office within the Office of the Secretary, a recommendation that was embraced by DOD and launched in 2011. SAMHSA continues to work closely with DSPO. Currently, SAMHSA is working with DSPO to review suicide prevention programs within DOD and develop a methodology to identify best practices.

In 2010, HHS Secretary Kathleen Sebelius and then DOD Secretary Robert Gates launched the National Action Alliance for Suicide Prevention ("Action Alliance"), a public-private partnership that advances the National Strategy for Suicide Prevention. Since its inception, the Action Alliance has been co-chaired by Secretary of the Army John McHugh and former U.S. Senator Gordon Smith. Among its 14 active task forces is the Military/Veterans Task Force, which last year co-hosted Partners in Care/suicide prevention summits in partnership with National Guard State Chaplains in five States. Through this initiative more than 400 community clergy were trained to recognize the warning signs of suicide among service members, veterans, and their families, and more than 200 congregations enlisted in a National Guard-sponsored Partners in Care program to provide support to National Guard members and their families. SAMHSA's grantee for the Suicide Prevention Resource Center acts as Secretariat for the Action Alliance, managing all operations.

SAMHSA is the lead HHS agency tasked with implementing the President's Executive Order "Improving Access to Mental Health Services for Veterans, Service Members, and Military Families," which was issued on August 31, 2012. SAMHSA is working closely with both DOD and the Department of Veterans Affairs (VA) on the outreach and public health aspects of the Order.

SAMHSA has been a planning partner with DOD and VA for the past three DOD/VA Suicide Prevention Conferences, offering the public health perspective needed to ensure community involvement in suicide prevention.

Through its Service Members, Veterans, and their Families Policy Academies and the ongoing technical assistance it provides after the Policy Academies, SAMHSA helps States and territories reach out to service members—especially members of the National Guard and Reserves—who are transitioning back to civilian life. The form of outreach varies across States/territories, but the work is generally done through State/Federal/private collaboration (*e.g.*, partnerships among State mental health and substance abuse agencies, Joining Forces and Joining Community Forces, Yellow Ribbon, VA, Veteran Service Organizations, etc.). Additionally, SAMHSA promotes military cultural training for community providers, which helps civilian providers better understand the military culture and appreciate the impact of deployment on both the service member and his/her family. Training also encourages providers to screen patients for military and combat experience and to make appropriate referrals to Vet Centers (which provide readjustment counseling to combat veterans, delivered by combat veterans) and to the VA.

In 2011, SAMHSA provided Applied Suicide Intervention Skills Training (ASIST) to 50 National Guard State directors of psychological health, and to 20 National Guard State suicide prevention program managers. ASIST is a "gatekeeper" program that trains individuals to recognize warning signs of suicide and to respond appropriately and effectively to those signs.

SAMHSA has worked closely with the VA since 2007 when VA launched the Veterans Crisis Line in partnership with SAMHSA and its National Suicide Prevention Lifeline. The Veterans Crisis Line is also co-branded the "Military Crisis Line," and marketing includes both names so that Veterans, Reservists, and Service members will feel welcome in calling this 24/7 life-saving resource.

Finally, one of SAMHSA's Government Project Officers in the Suicide Prevention Branch provides both Marines and Sailors with suicide prevention training. SAMHSA is working with the U.S. Marine Corps to extend the current Memorandum of Understanding.

*Question 3*. How can we help you to strengthen the mental health workforce? Is there anything you need from us?

Answer 3. As outlined in the President's plan, *Now is the Time*, the Administration is proposing funding to train 5,000 behavioral health professionals, particularly those interested in working with school and transition-age youth. To achieve this goal the Administration is proposing $50 million for a behavioral health workforce program to train social workers, counselors, psychologists, and other mental health professionals.

*Question 4*. Are reforms needed in the substance abuse prevention and treatment block grant or community mental health services block grant to better meet the needs of patients in our communities?

Answer 4. We will continue to review the block grant requirements as the health care law is implemented and look forward to working with Congress to continue to meet the needs of patients in our communities.

SENATOR MURRAY

*Question 1*. In 2008 this committee, under Chairman Kennedy, helped to pass into law the Mental Health Parity and Addiction Equity Act. This law, expanded in the recent health care reform legislation, requires health insurance to cover both mental and physical health equally. As you know, three parity provisions were included in the President's recently released gun violence package: one clarifying parity for Medicaid managed care plans, one saying a parity provision would be included in the final essential health benefits rule, and one that "committed" to issuing the final rule on the Mental Health Parity and Addiction Equity Act, but it did NOT make clear when we might expect to see that. If plans are supposed to be ready to go in Exchanges starting in October, it is essential that we see a final rule no later than April.

Can you give us a date certain on when the final rule will be released?

Answer 1. The Administration intends to issue the final rule on the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) by the end of 2013. To date, the three different agencies—HHS, Treasury, and Labor—that have responsibility for these rules, have released an Interim Final Rule (IFR) and multiple guidance documents, in the form of FAQs and compliance aids, to provide guidance on substantive issues necessary for Exchanges to move forward with guidance to their Qualified Health Plans.

*Question 2*. Parity in scope of services has to be defined in the final rule. I have heard reports of plans that are dropping key mental health and addiction services like intensive outpatient and residential treatment, even if similar services are provided for medical conditions, because the law's interim final rule did not address the issue of scope of service.

How will you define parity in scope of services in the final rule to ensure that patients are able to access important mental health services?

Answer 2. The Administration is studying this issue very carefully and is closely reviewing comments received on the IFR. In addition, we are reviewing regulations in States that have enacted parity laws to assess how they have treated scope of services and examining how private health insurance currently covers and pays for services such as intensive outpatient and residential treatment. The Administration has also obtained clinical opinions and reviewed literature regarding what the analogous services are to residential and intensive outpatient.

*Question 3*. The final rule needs to clarify how non-quantitative treatment limits apply by setting a quantitative floor. In December 2011, the Department of Labor, the Department of the Treasury, and the Department of Health and Human Services released a set of frequently asked questions that aimed to provide additional guidance on these treatment limits. These FAQs established that non-quantitative treatment limits must be applied "comparably and no more stringently" to mental

health and substance abuse benefits than to medical benefits. However, many plans are currently claiming that regulations allow them to micro-manage mental health and addiction treatment the same way plans manage physical therapy, which makes up less than 1 percent of medical benefits. Applying a non-quantitative treatment limit more stringently to all behavioral health benefits and only 1 percent of medical benefits is not comparable and violates. A quantitative floor for non-quantitative treatment limits is needed to clarify these limits so that plans do not apply them in a way that violates the Mental Health Parity and Addiction Equity Act.

How do you plan to clarify in the final rule how non-quantitative treatment limits apply? Will you include a quantitative floor in the final rule?

Answer 3. The Departments issued a number of FAQs to help clarify these issues and will continue to do so through FAQs and the final rule. Non-quantitative treatment limits (NQTLs) were the focus of FAQs that were released on November 17, 2011. In those FAQs it was explained that the quantitative tests outlined in the IFR for determining what limits or requirements apply to substantially all medical/surgical benefits and what the predominant levels for those financial requirements or limits are do not apply to NQTLs. In addition, other FAQs clarified that applying standards used for a very limited set of medical/surgical benefits, for instance just physical therapy to all mental health and substance use disorder benefits, would not be permissible (see FAQ #5).

*Question 4*. The final rule must require transparent disclosure of medical and behavioral criteria so that parity compliance testing may be performed. The Parity Implementation Coalition has provided 100 cases to the Department of Labor and the Department of Health and Human Services of plans refusing to provide this essential information. No plan, to my knowledge, has ever disclosed these criteria, and there has been no enforcement of that requirement that I am aware of in the 4 years that the law has been out.

How will you enforce the requirement that health insurance plans to disclose medical and behavioral criteria?

Do you have a plan to retroactively handle the Parity Implementation Coalition's complaints about plans refusing to disclose criteria over the past 4 years?

Answer 4. The Department of Labor (DOL) has primary oversight of private employer-sponsored group health plans, and States have primary oversight of health insurance issuers (with HHS having fallback oversight for issuers). During the 2 years (since January 2011) that the regulations have been fully in effect for most plans, DOL has been committed to ensuring that individuals enrolled in employer-sponsored health plans receive mental health and substance use benefits in a manner that is compliant with MHPAEA. DOL, for example, has a robust investigative program in 10 field offices across the country that conduct health plan audits to check for compliance with various Federal laws, including MHPAEA. Any concerns or inquires brought to DOL's attention are thoroughly evaluated and reviewed, including those related to mental health parity. Many of these reviews and audits are handled under a voluntary compliance and correction approach, and resolved through confidential discussions between DOL and the group health plan. In general, for cases involving a group health plan providing coverage through a fully insured health insurance product, DOL works closely with States and HHS to resolve the issues at the health insurance issuer level. HHS regularly works with State insurance commissioners to address complaints that have been made about a variety of matters related to MHPAEA. Some of these involve disclosure of medical necessity criteria, which, as such, are handled confidentially.

SENATOR CASEY

*Question 1*. You noted that Medicaid accounts for 28 percent of mental health spending. In your experience, are mental health patients more vulnerable to Medicaid cuts than patients with physical health problems?

Answer 1. Individuals with mental illnesses tend to have lower incomes, higher health care expenditures, and are more likely to be enrolled in public insurance programs like Medicaid. Therefore they are more susceptible to cuts in the program. When cuts are made to Medicaid, it can impact one or more services that the individual is relying on.

*Question 2*. What kind of impact can even small changes in Medicaid spending have on access to mental health services?

Answer 2. The Administration gives States significant flexibility to manage costs and benefits in their programs. CMS continues to work closely with States to provide options and tools that make it easier for States to make changes in their Medicaid programs to improve care and lower costs. In the last 6 months, the Adminis-

tration has released guidance giving States flexibility in structuring payments to better incentivize higher-quality and lower-cost care, provided enhanced matching funds for health home care coordination services for those with chronic illnesses, designed new templates to make it easier to submit section 1115 demonstrations and to make it easier for a State to adopt selective contracting in the program, and developed a detailed tool to help support States interested in extending managed care arrangements to long-term services and supports.

*Question 3*. Which groups of Medicaid beneficiaries tend to use mental health services the most?

Answer 3. Historically, given the varying types of Medicaid coverage levels by State, it has typically been children with serious emotional disturbance, and adults who have been found to be disabled due to a mental illness that have been most often covered by Medicaid, and therefore present in the data as users of service. In addition, persons who are dually eligible for Medicare and Medicaid often present with complex mental health needs.

SENATOR BENNET

*Question 1*. Most private health insurance does not offer a comprehensive mental health or substance use disorder benefit. While parity takes an important step by requiring that these areas of health care are covered at the same level as physical health care, there is a lack of detailed information. Current listings of services under essential health benefits do not provide sufficient detail on parity with mental health and substance use services that are effective and necessary. Consequently, there is concern that expanded Medicaid and new products on the Exchanges will not offer the necessary services available for patients who need mental health and substance use disorder treatment and prevention. Does SAMHSA recommend further guidance for States and health plans on the required mental health and substance use services that each plan must offer in their essential benefit plan? If so, what should that guidance include?

Answer 1. The Affordable Care Act will provide one of the largest expansions of mental health and substance use disorder coverage in a generation. Beginning in 2014, under the law, all new small group and individual market plans will be required to cover 10 Essential Health Benefit categories, including mental health and substance use disorder services, and will be required to cover them at parity with medical and surgical benefits. The Affordable Care Act builds on MHPAEA (the Federal parity law), which requires group health plans and insurers that offer mental health and substance use disorder benefits to provide coverage that is comparable to coverage for general medical and surgical care.

The Affordable Care Act builds on MHPAEA to extend Federal parity protections to 62 million Americans. The parity law aims to ensure that when coverage for mental health and substance use conditions is provided, it is generally comparable to coverage for medical and surgical care. The Affordable Care Act builds on the parity law by requiring coverage of mental health and substance use disorder benefits for millions of Americans in the individual and small group markets who currently lack these benefits, and expanding parity requirements to apply to millions of Americans whose coverage did not previously comply with those requirements.

*Question 2*. Mental Health First Aid has the great potential to identify people with emerging mental health issues and substance use disorders. In many cases, identification can result in referrals to primary care, mental health, and substance use treatment providers. Most public and private funding does not pay for early intervention and prevention services for people with mental health issues and substance use disorders. Often, mental health coverage does not exist until a person has a diagnosable condition. By funding prevention and early intervention, diagnosis and more expensive treatment may not be necessary. What efforts are SAMHSA and NIMH engaged in to promote more prevention and early intervention services and to remove restrictions that require a higher degree of illness before a person can get needed care?

Answer 2. SAMHSA supports a number of grant programs and initiatives that promote more prevention and early intervention services. Examples include:

• *Linking Actions for Unmet Needs in Children's Health* (*Project LAUNCH*): Project LAUNCH is a program that seeks to ensure that all young children, especially those at increased risk for developing social, emotional, and behavioral problems, receive the supports they need to succeed. Project LAUNCH brings together stakeholders to develop a vision and a comprehensive strategic plan for promoting the wellness of all young children. Project LAUNCH also supports programs for

child care providers such as Mental Health Consultation, which can address behavior problems before they disrupt placements and lead to later problems.

• *Implementing Evidence-Based Prevention Practices in Schools* (*PPS*): The purpose of this program is to prevent aggressive and disruptive behavior among young children in the short term and prevent antisocial behavior, suicidal ideation, and the use of illicit drugs in the longer-term with the additional goal of promoting graduation from high school.

• *Safe Schools/Healthy Students Initiative* (*SS/HS*): SS/HS is a unique collaboration between HHS, the Department of Education, and the Department of Justice. SS/HS takes a broad approach, drawing on the best practices and the latest thinking in education, justice, social services, and mental health to help communities take action, recognizing that no single activity can be counted on to prevent violence. SS/HS supports local education agencies across the country, spanning rural, Tribal, suburban, and urban areas as well as diverse racial, ethnic, and economic sectors. It provides grant funds, technical assistance, and evaluations of both process and outcome (effectiveness) measures. To date, SS/HS has provided services to over 12 million youth and more than $2 billion in funding and other resources to 365 communities in 49 States across the Nation. Outcomes of SS/HS grantees suggest that partnership was the key factor in success. There was a dramatic 263 percent increase in the number of students who received school-based mental health services and an astounding 519 percent increase in those receiving community-based services. Nearly 80 percent of school staff stated that they were better able to detect mental health problems in their students and more than 90 percent of school staff reported that they saw reductions in alcohol and other drug use among their students.

The President's gun violence reduction package released in January includes $40 million to expand SS/HS through Project AWARE.

• *National Center for Mental Health Promotion and Youth Violence Prevention* (*National Center*): The National Center provides training and technical assistance to support prevention and early intervention activities as well as directed TA to Safe Schools/Healthy Students and Project LAUNCH grantees. National Center staff work with school districts and communities as they plan, implement, and sustain initiatives that foster resilience, promote mental health, and prevent youth violence and mental and behavioral disorders. Through training, national and regional events, teleconferences, online learning, site visits, peer exchange, a virtual library, and onsite work, the National Center provides culturally competent consultation to serve diverse audiences.

• *Screening, Brief Intervention and Referral to Treatment* (*SBIRT*): SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders. Primary care centers, hospital emergency rooms, trauma centers, and other community settings provide opportunities for early intervention with at-risk substance users before more severe consequences occur.

SENATOR ENZI

*Question*. I am concerned about the significant number of duplicative Federal Government programs. Can you tell me what programs within your agency are duplicative or could be combined to provide more efficient operations? Please describe how you plan to identify unfunded and unproven programs that can be eliminated in order to better focus resources on those that do work.

Answer. SAMHSA takes its role as a steward of taxpayer dollars very seriously and during this tight budget environment, SAMHSA stretches every dollar we have to make the maximum impact. We closely examine our portfolio at SAMHSA to find efficiencies and as a result have reduced redundancy or duplication. For example, in 2012, SAMHSA consolidated three State Technical Assistance (TA) contracts into a single contract. This consolidation resulted in both programmatic as well as administrative efficiencies. In 2011, several similar consolidations took place. SAMHSA constantly evaluates its programs via grantee input and data collection. Program adjustments, in scope or focus, are directly affected by that data. With the development and implementation of the Common Data Platform, program adjustments will be even better informed in the future.

RESPONSE BY THOMAS INSEL, M.D. TO QUESTIONS OF SENATOR ALEXANDER, SENATOR MIKULSKI, SENATOR CASEY, AND SENATOR ENZI

SENATOR ALEXANDER

*Early Diagnosis of Mental Disorders*

*Question.* Much of NIMH's work has the potential to have major impacts on the mental health system overall, with the ability to diagnose mental disorders earlier and get people, especially young children, into effective treatment. Can you provide some examples of work that you are doing to diagnose mental disorders earlier?

Answer. One of the primary objectives of the NIMH Strategic Plan [1] is to chart the course of mental disorders over the lifespan to determine when, where, and how to intervene, with the ultimate goal of preempting or treating mental disorders and hastening recovery. Mental disorders are a group of chronic, changing conditions. The symptoms often begin to appear in childhood and adolescence and ebb and flow over the course of an individual's life. Behavioral manifestations, such as psychosis and depression, are in fact late events in the timeline of illnesses that began years earlier.[2] As with many other illnesses, science promises to redefine mental disorders along a trajectory moving across stages of risk: from early symptoms, to full symptoms or syndromes, to remission, relapse, and recovery. NIMH aims to compare trajectories of healthy development to those of mental disorders in order to better understand the first instance or instances when development moves off course. Doing so will allow us to pinpoint the best times and techniques to preempt the onset of symptoms or halt and reverse the progression and recurrence of illness. Charting the course of mental disorders requires attention to genetic, neurobiological, behavioral, experiential, and environmental factors that confer a risk of developing a mental disorder.

NIMH is supporting considerable research to chart these trajectories in order to intervene early. For example, the NIMH-funded Neurodevelopmental Genomics project is a landmark study in developmental neuropsychology that will bridge our understanding of brain and behavioral development for children ages 8 to 21. The study began with 10,000 children whose genomic profiles and cognitive abilities would be studied, with 1,000 undergoing comprehensive neuroimaging throughout brain development. The data are still being analyzed, but the study has already provided the first detailed reference map of cognitive development across adolescence. This project is giving us a picture of the range of development in both brain and behavior with which we can map expected trajectories, similar to growth charts for height and weight.

NIMH-supported researchers are also working to identify individuals who may develop schizophrenia, a chronic, severe, disabling brain disorder that affects more than 2 million Americans age 18 and older in a given year.[3] Although we know from other areas of medicine that early detection and early intervention yield the best outcomes, we lack the predictive markers for early detection of schizophrenia. Some individuals with schizophrenia will experience episodes of psychosis, a loss of contact with reality that usually includes false beliefs about what is taking place or who one is (delusions) and seeing or hearing things that are not there (hallucinations). Most young people have pre-psychotic symptoms, known as the prodrome, for 2–3 years before the onset of psychosis. To enhance early detection and preempt psychosis, NIMH is supporting the North American Prodrome Longitudinal Study (NAPLS), a consortium of eight clinical research centers studying the prodromal phase of schizophrenia. The investigators are using biological assessments, including neuroimaging, electrophysiology, neurocognitive testing, hormonal assays, and genomics, to improve our ability to predict who will convert to psychosis, and to develop new approaches to pre-emptive intervention.

While some do not necessarily consider autism a traditional mental health disorder, the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) published by the American Psychiatric Association includes Autism Spectrum Disorder. NIMH research has also made great advances in the early diagnosis for autism spectrum disorder (ASD). ASD is a neurodevelopmental disorder that typically manifests before the age of 3 years and is associated with a range of difficulties in social inter-

[1] *http://www.nimh.nih.gov/about/strategic-planning-reports/index.shtml.*

[2] Cannon TD, Cadenhead K, Cornblatt B, Woods SW, Addington J, Walker E, Seidman LJ, Perkins D, Tsuang M, McGlashan T, Heinssen R. Prediction of Psychosis in High Risk Youth: A Multi-Site Longitudinal Study in North America. *Arch Gen Psychiatry*. 2008 Jan;65(1):28–37.

[3] Regier DA, Narrow WE, Rae DS, Manderscheid RW, Locke BZ, Goodwin FK. The *de facto* mental and addictive disorders service system. Epidemiologic Catchment Area prospective 1-year prevalence rates of disorders and services. *Archives of General Psychiatry*. 1993 Feb;50(2):85–94.

action, communication, and repetitive behaviors. Early detection of ASD may lead to earlier intervention which in turn may lessen, or even eliminate, ASD symptoms for some children. Yet identifying the earliest signs of ASD has been challenging. However, NIMH supported researchers have recently shown that it is possible to detect the earliest signs of ASD in 6-month-old infants. The researchers followed a group of infants from 3 months to 3 years of age. The infants were assessed in their third year of life when some of them were found to have ASD. Compared to the typically developing infants, infants later diagnosed with ASD showed a decreased ability to pay attention to complex social scenes involving people and objects. The researchers posit that difficulties in attending to people might precede the excessive interest in objects often reported in older children with ASD. Thus, some of the first signs of ASD, such as limited visual attention to social scenes, may be detectable very early in development, well before the emergence of current diagnostic features.[4]

SENATOR MIKULSKI

*Premature Mortality and Mental Illness*

*Question*. Are we doing all that we can to reduce premature deaths associated with mental illness?

Answer. Research shows that Americans with serious mental illness (SMI) die 8 years earlier than the general population from largely preventable or treatable comorbid medical conditions, such as heart disease, diabetes, cancer, pulmonary disease, and stroke.[5] Low rates of prevention, detection, and treatment further add to these health disparities.

To address this serious public health concern, in 2012, NIMH convened the meeting "Research to Improve Health and Longevity of People with Severe Mental Illness," in collaboration with the National Institute on Diabetes and Digestive and Kidney Diseases (NIDDK), the National Heart, Lung, and Blood Institute (NHLBI), the National Cancer Institute (NCI), and the National Institute on Drug Abuse (NIDA). The meeting brought together the leading researchers on medical comorbidities in people with SMI and on prevention and treatment within the general population for diabetes, heart disease, tobacco use, and drug abuse. They were joined by State policy leaders; advocates for people with SMI; leaders of community mental health centers; and representatives from key Federal agencies, including the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Agency for Healthcare Research and Quality (AHRQ). The goal of the meeting was to identify critical research gaps and formulate the most pressing research questions in order to improve the health and longevity of people with SMI. This meeting informed the development of a new funding announcement that NIMH will release this year, titled *Improving Health and Reducing Premature Mortality in People with Severe Mental Illness* (*SMI*). The goal of this initiative is to test services interventions that specifically target people with SMI or children and youth with serious emotional disturbances and modifiable health risk factors that are the primary causes of premature mortality in these populations.

In addition to supporting research to extend longevity by treating comorbid medical conditions, NIMH is engaged in numerous suicide prevention efforts. Suicide is the 10th leading cause of death in the United States, accounting for the loss of more than 38,000 American lives each year, more than double the number of lives lost to homicide.[6] The National Strategy for Suicide Prevention[7]—developed by the National Action Alliance for Suicide Prevention—emphasizes the importance of research that can help develop effective interventions. NIMH co-leads the Research Task Force of the Action Alliance, which is developing a detailed research agenda, anticipated in 2013, that pledges to provide a roadmap for reducing suicide by 20 percent in 5 years, and 40 percent or more in 10 years.

The challenge of reducing suicide is especially urgent in the military. Recognizing that this is not only a military problem but also a national challenge, the Army Study to Assess Risk and Resilience in Servicemembers[8] (Army STARRS) was

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[4] Chawarska K, Macari S, Shic F. Decreased Spontaneous Attention to Social Scenes in 6-Month-Old Infants Later Diagnosed with Autism Spectrum Disorders. *Biological Psychiatry*, published online January 10, 2013.

[5] Druss BG, Zhao L, Von Esenwein S, Morrato EH, Marcus SC. Understanding excess mortality in persons with mental illness: 17-year followup of a nationally representative U.S. survey. *Med Care*. 2011 Jun;49(6):599–604.

[6] Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS): *www.cdc.gov/ncipc/wisqars* accessed October 2012.

[7] More information at: *http://actionallianceforsuicideprevention.org/NSSP*.

[8] *http://armystarrs.org/*.

launched in fiscal year 2009. Army STARRS is a 5-year collaborative partnership between the Department of the Army, NIMH, and several academic institutions that seeks to identify factors that both protect Soldiers' mental health and those that put a Soldier's mental health at risk. The ultimate goal of Army STARRS is to provide empirical evidence to help the Army develop targeted prevention and treatment strategies.

In fiscal year 2012, Army STARRS reached a number of milestones, including establishing survey sites at more than 70 locations around the world, surveying more than 100,000 Soldiers, and, with appropriate consent, collecting more than 56,000 blood samples. Both the New Soldier Study, designed to capture information about experiences soldiers bring into the Army, and the All Army Study, which provides a snapshot of the Army across ranks and all areas of service, are nearing completion. This past year, several new components were launched, and Army STARRS established a data enclave that integrates the administrative records of the 1.6 million Soldiers who served between 2004 and 2009. The enclave and its more than 1.1 billion pieces of data are part of a massive epidemiological approach to studying the complexities of Soldiers' mental health.

Brain disorders are incredibly complex. The array of paths that lead to post-traumatic stress disorder and suicide are as diverse as the individuals affected. Army STARRS has shown that no single approach will yield the answers needed to solve these difficult problems. A White House Executive order released in August 2012 directs Federal agencies to improve coordination and integrate research on mental health and suicide prevention strategies.[9] This Order provides a platform that will lead to more robust partnerships, capitalizing on the resources of multiple Federal departments and agencies, as well as the intellectual power of academic institutions. Army STARRS is an unprecedented example of how collaboration both within and outside of government is working to improve the lives of Servicemembers and civilians by developing better prevention, diagnosis, and treatment strategies. NIMH is also working with Marines on a separate effort supported by the Marine Corps which is synergistic with the Army STARRS project. This effort is advisory, assisting the Marines in making decisions about how to proceed with their project, and seeking to bring the Marine study investigators into a collaborative working relationship with those involved in Army STARRS.

SENATOR CASEY

*Funding for Pediatric Mental Illness*

*Question 1*. What percentage of your funding goes to research into mental illnesses that affect children, or to the early phases of illnesses that may not fully manifest until adulthood, but often have roots in childhood?

Answer 1. Approximately 28 percent of the NIMH budget was devoted to pediatric research in mental health in fiscal year 2011 (the most recent year for which this data is available).

Regarding the derivation of this percentage: In January 2009, NIH implemented a new reporting tool called Research, Condition, and Disease Categorization (RCDC). RCDC is a computerized process that NIH uses to categorize and report the amount it funded in each of 233 reported categories of disease, condition, or research area. The following table represents data derived from the intersection between two RCDC categories: "pediatric" and "mental health" for fiscal year 2011. This table represents NIMH-administered records only. RCDC data are publicly available via the NIH RePORT Web site.[10]

| Fiscal year | Number of pediatric mental health projects | Total pediatric mental health spending | Total NIMH budget | Percent of NIMH budget |
|---|---|---|---|---|
| 2011 ...................... | 1,144 | $414M | $1,475M | 28 |

*Unique Considerations in Pediatric Mental Health Research*

*Question 2*. Are there unique considerations to conducting mental health research with children, as opposed to adults, that are different from other types of pediatric research?

Answer 2. Yes, the unique features of the developing brain distinguish pediatric mental health research from other types of pediatric research. Advances in our understanding of the molecular, structural, and functional aspects of brain develop-

[9] *http://www.whitehouse.gov/the-press-office/2012/08/31/executive-order-improving-access-mental-health-services-veterans-service.*

[10] *http://report.nih.gov/categorical__spending.aspx.*

ment have led to the discovery of striking changes that occur in the brain during adolescence—changes in the strength and efficiency of communication between different parts of the brain, notably in the frontal cortex, which is responsible for impulse control and long-range planning. An important concept from this research is that the brain does not resemble that of an adult until the mid–1920s. Thus, from a neuroscience perspective, adolescents are not merely mini-adults. This insight suggests that we must address mental illnesses, from ASD to schizophrenia, as developmental brain disorders with genetic and environmental factors leading to altered circuits and behavior. Understanding the causes and nature of malfunctioning brain circuits in mental disorders may make earlier diagnosis possible. Interventions could then be tailored to address the underlying causes directly and quickly, changing the trajectory of these illnesses.

Children also present challenges with regard to "self-reporting" in mental health research, which is part of the typical diagnostic method. In many cases, young children have limited cognitive capacity and ability to convey information about themselves and their experience. Furthermore, many mental health issues are associated with developmental delays, which also compromise a child's ability to report or participate effectively in research. These issues underpin the necessity of research to find biological markers for mental disorders. Through the PROMIS initiative NIMH has been an active partner in an NIH-wide effort to develop validated patient and parent reported outcome measures for use in assessment of pain, depressive symptoms, and anxiety in children in clinical trials.[11]

In addition to the complexities of developmental changes, it is critical to understand what types of interventions work best for the unique needs of pediatric populations and to deliver these interventions appropriately. NIMH supports several clinical research studies on behavioral interventions, medications, or combination treatment approaches. Effectiveness trials are currently comparing interventions to treat children and adolescents with anxiety, major depression, and ASD. In recent years, NIMH has funded a number of studies to understand the benefits and risks of using psychotropic medications in children; more research is needed to understand the effects of these medications, especially in children under 6 years of age. Each child has individual needs, and must be monitored closely while taking these medications. Several studies in progress are seeking to identify ways of preventing, minimizing, or reversing common adverse effects of medications, such as weight gain, during antipsychotic treatment. Future research will be on developing safer and more effective interventions (both behavioral and pharmacological) that are tailored to each child's individual needs and characteristics. Another focus will be on preventing the onset of mental illness by intervening early among children who are at especially high risk or who have initial symptoms, before the full onset of the disorders.

SENATOR ENZI

*Coordination of Federal Programs*

*Question*. I am concerned about the significant number of duplicative Federal Government programs. Can you tell me what programs within your agency are duplicative or could be combined to provide more efficient operations? Please describe how you plan to identify unfunded and unproven programs that can be eliminated in order to better focus resources on those that do work.

Answer. NIH makes every effort to eliminate or amend overlap regardless of the funding source prior to awarding research funding. NIH's review for potential duplication begins immediately after the application is submitted to NIH. Each application is reviewed against previous submissions to ensure it is "new" with significant and substantial changes in content and scope, rather than a resubmission of an earlier application. The competitive NIH two-tier review process includes scientific and technical review and consideration by an advisory council that includes public representatives. Prior to the final funding decision, applicants are instructed to submit "Just-in-Time" material, which includes a declaration of current other support the applicant is receiving—*i.e.*, all financial resources, whether Federal, non-Federal, commercial or institutional, available in direct support of an individual's research endeavors, including but not limited to research grants, cooperative agreements, contracts, and/or institutional awards. Furthermore, NIH investigates three forms of overlap: scientific (conceptual); budget (salary, equipment); and personnel (overcommitment of time to work on the project). NIH has taken and will continue to take steps to exemplify and promote the highest level of scientific integrity, public accountability, and social responsibility in the conduct of science.

[11] *http://www.nihpromis.org/default*.

RESPONSE BY MICHAEL HOGAN, PH.D. TO QUESTIONS OF SENATOR ALEXANDER, SENATOR MIKULSKI, SENATOR ENZI, AND SENATOR CASEY

SENATOR ALEXANDER

*Question.* I'm interested in making things easier for States as they tackle the mental health and substance abuse problems facing individuals and families in their communities. What are one or two things the Federal Government can do to make the money we now spend easier to use and help States in this effort?

Answer. Crucial to this issue is that most of the Federal funding relevant to fighting addiction and mental illness at the State level is Medicaid. The block grants administered by SAMHSA (Mental Health, Substance Abuse Treatment and Prevention) are relatively minor by comparison. SAMHSA has done a pretty good job of making the block grant application and review processes simpler. Ability to use prevention funds to fight both mental illness and addiction would be a very good idea. Addictions constituents resist this on the grounds that not enough is done to fight addiction, however many health and behavioral problems are linked and good prevention efforts such as effective parenting programs help with many problems.

Medicaid is I think the responsibility of the Finance Committee but flexibility in Medicaid would help the States *as long as standards for and levels of behavioral health treatment were maintained*. For example, Medicaid should support effective prevention programs.

SENATOR MIKULSKI

*Question 1.* What barriers still exist with regard to achieving parity in mental health and medical benefits for patients with Medicaid, CHIP, Medicare, and private insurance?

Answer 1. As my written testimony indicates, Dominici-Wellstone goes very far on this issue. I am confident the Administration's admittedly overdue parity regs will be ok. The bigger problem is that parity by definition applies to mental health specialists, while the biggest mental health access issue is a failure to address mental health *in primary care*. This problem must be addressed. Health plans must pay for basic mental health care in primary care. The integrated care model known as *collaborative care* is proven effective in over 40 research studies, yet Medicare and many private plans do not cover the elements of collaborative care. It is also crucial that parity not become an unintended barrier to improving "primary mental health care." The issue here is the necessity of payment to primary care for this work; if the parity benefit goes only to specialists it is self-defeating. The Massachusetts Medicaid program is implementing an innovative approach to address this problem. The DIAMOND collaboration in Minnesota is another excellent approach.

*Question 2.* I am a big champion of privacy but with Virginia Tech, none of the systems talked with each other. How can we make sure privacy is protected and everyone in the system is talking to each other when problems arise?

Answer 2. My opinion is the problem is more basic. The Supreme Court's *Tarasoff* standard overrules privacy; if there is a clear risk, clinicians are obligated to report/take reasonable steps today. The deeper problem (addressed in my written testimony) is that we have no national approach to treatment of emergent or "First Episode Psychosis." Young people with these problems—and several recent mass murderers appear to fit this profile—have no system of care . . . so isolated practitioners are left to provide this care on their own. Dr. Lisa Dixon (formerly of U. MD., now at Columbia) is developing a network of these programs in New York. Dr. Brian Hepburn, the Maryland mental health commissioner, is familiar with this work. Oregon has a well-developed network. With First Episode Psychosis programs in place, there would be an expectation of care coordination and communication with college personnel. *Absent a network of FEP programs, changes in the law will be ineffective*.

*Question 3.* Are reforms needed in the substance abuse prevention and treatment block grant or community mental health services block grant to meet the needs of patients in our communities?

Answer 3. Reforms in these grants are mostly not crucial. They are very small components of the behavioral health programs in the States. SAMHSA has improved their administration. Improved attention to behavioral health in CMS is a much bigger problem. The Obama administration has done more here (for example the Health Homes program in Medicaid, and consultation with SAMHSA) but this is still not adequate. CMS must attend to mental health needs better in both Medicare and Medicaid.

SENATOR CASEY

*Question 1.* Thank you for sharing your insights and your suggestions, both practical and philosophical, about what steps we can take to improve our mental health system. I am intrigued by your description of First Episode Psychosis care that is being used successfully in several other countries. Could you describe this approach in greater detail? Are there specific barriers to its adoption that we are facing in the United States?

Answer 1. The First Episode Psychosis approach was implemented widely in Australia under the leadership of Dr. Patrick McGorry. In the United States, the best developed approach is in Oregon, where about 70 percent of the State is now covered. A good description of the program is available at *www.eastcommunity.org*. If I may be blunt, the biggest obstacle is that we are simply behind the times and the needs of patients on this. The fact that we have had a separate mental health system that focused on the "seriously and persistently mentally ill" meant indirectly that young people's mental health in general has been neglected. The programs we have could often be called "late intervention." There are many barriers to a good approach to FEP, including that paying for the required team approach to care may be challenged by insurers as excessive. But it is essential. At its core, FEP care is a community-based approach similar to care in a modern cancer center. It is team-based, family-centered, and holistic. It uses a treatment plan consistent with what the patient and family will accept, but aims for care that meets the highest and best researched standards for effectiveness.

*Question 2.* Is there a widespread recognition among primary care physicians that treating mental health issues is also an important part of treating physical health? How can awareness of this matter be improved among primary care physicians?

Answer 2. Awareness among PCP's is very uneven, but many of them know that they are dealing with behavioral issues—especially family physicians and pediatricians. The bigger problems are that national standards for behavioral care in primary care are inadequate—and because we have a separate mental health system, we reserve payment for behavioral care to specialists. We need widespread promotion of the Collaborative Care model, and an understanding that Medicaid, Medicare and commercial payers will cover collaborative care. Evidence shows that savings from reduced medical care will more than pay for better depression care in primary care.

*Question 3.* Have providers developed any innovative ways to stretch resources after facing State or Federal budget cuts? Are there any models that stand out for successfully operating on reduced funds that could be emulated by other providers or local officials?

Answer 3. In my opinion the major innovation that is needed—and now happening—is an emphasis on "integrated care" whereby basic behavioral and other medical problems are handled by the same team, with specialists only called in when problems really require it. This is happening in many (but not all) Community Health Centers, in some Mental Health Centers (e.g. in Missouri) that are now coordinating their consumers' medical care. We have learned that people who have major chronic health problems (like diabetes, heart disease) and also mental health problems have total health costs that are 30–70 percent higher than people with comparable medical illnesses but no depression. Integrated continuous care helps them manage their health better, reducing hospitalizations and ED visits. In my view, this trend toward integration may be part of the reason why recent reports show reduced medical inflation.

There are still many barriers to integration. The Federal Government is trying to help, but much more needs to be done. My discussion of collaborative care above illustrates this. Medicare still does not cover its elements adequately. And the barriers in separate mental health and medical plans can prevent responsible integration. Of course, there remains a tendency for health plans to depress levels of mental health service. Integration with basic requirements for mental health services is essential.

SENATOR ENZI

*Question.* What can be done to educate local communities about identifying risk factors for mental illness and substance abuse? How do we improve access to treatment? What is working and what is not working?

Answer. We must do a better job with prevention. The evidence is clear that these problems begin in childhood. For example, maternal depression can impair a mother's ability to parent well. If she is single with multiple children, the problems are

compounded. Treating mom's depression reduces levels of mental health problems in her children by 50 percent *without directly treating the children*. Our failure to intervene early with children who have moderate levels of mental health concerns (that could usually be addressed through parent support and training, behavioral services in pre-school and age-appropriate psychotherapy) leads to use of powerful medications and to other expensive interventions later on. As I said in the hearing, we have an admirable national early intervention program for kids with developmental disabilities, but for kids with emotional challenges we wait for years and then often just use meds.

The single biggest thing we could do in the short term is to make sure that basic mental health care is a core element of primary care in Medicaid, under State Insurance Exchanges, and in Community Health Centers. This early intervention approach can address many health problems and is cheaper than specialty care. It is applicable for pediatrics and geriatrics. But primary care must have access to reimbursement for these basic services known as Collaborative Care.

## RESPONSE BY ROBERT N. VERO, ED.D. TO QUESTIONS OF SENATOR ALEXANDER, SENATOR MIKULSKI, SENATOR ENZI, AND SENATOR CASEY

### SENATOR ALEXANDER

*Question 1.* I'm interested in making things easier for States as they tackle the mental health and substance abuse problems facing individuals and families in their communities. What are one or two things the Federal Government can do to make the money we now spend easier to use and help States in this effort?

Answer 1. First, it would be helpful for the Federal Government to **create a Federal definition for Federally Qualified Behavioral Health Centers (FQBHCs).** There was a definition for Community Mental Health Centers (CMHCs) for more than the first 20 years of their existence, but this was lost in the 1980s.[1] This has resulted, too often, in poor outcomes, serious gaps in services from State to State, and the growth of mental health agencies that provide only some (or none) of the core services necessary for community-based care that still call themselves "community mental health centers" and, likewise, still bill Medicaid and Medicare.[2][3] There is a key provision within the Excellence in Mental Health Act that proposes a definition and, moreover, delineates the minimally expected array of services.

1. If States chose to contract with FQBHCs, they could ensure communities are able to access a full continuum of high quality, evidence-based, mental health and addiction services. Sadly, most current public policies do not hold health providers accountable for providing value-based services.[4]

2. The proposed definition would ensure that the provider offers **mobile (face-to-face) crisis mental health** services within their local community. This is a proven strategy to deter unnecessary psychiatric hospitalizations and prevent community tragedies. While many providers currently provide crisis hotlines, their continuum of crisis services would be unquestionably strengthened with the addition of mobile crisis services. These face-to-face assessments are often invaluable interventions, also reducing unwarranted arrests and incarcerations. State costs are reduced significantly when there are local teams, available 24-hours per day (365 days per year), interfacing with law enforcement, hospital emergency departments and concerned family members to provide emergency assessment to people in crisis.

3. Another issue the Federally Qualified Behavioral Health Center definition could address is the concern States have with access to care. Too often, profit-motivated providers have cherry-picked high-revenue services, leaving some parts of our communities without access to care—especially in rural areas. The current fragmented behavioral healthcare system has resulted in only ⅓ of rural counties and 63 percent of all U.S. counties having "at least one mental health facility with any

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[1] Goldman H & Grob G. (2006). Defining "mental illness" in mental health policy. *Health Affairs*. 25(3): 737–49. Retrieved on February 21, 2013 from *http://content.healthaffairs.org/content/25/3/737.full*.

[2] Cummings JR, Wen H, & Druss BG (2013). Improving access to mental health services for youth in the United States. *Journal of the American Medical Association*. 309(6): 553–54.

[3] Department of Health and Human Services Office of the Inspector General. (January 2013) *Vulnerabilities in CMHS' and Contractors' Activities to Detect and Deter Fraud in Community Mental Health Centers*. OEI–04–11–00101. Retrieved on February 21, 2013 from *https://oig.hhs.gov/oei/reports/oei–04–11–00101.pdf*.

[4] Lehman AF, Goldman HH, Dixon LB, & Churchill R. (2004). *Evidence-based mental health treatments and services: Examples to inform public policy*. New York: Millbank Memorial Fund.

special programs for youth with severe emotional disturbance" (Cummings, Wen & Druss, 2013, 553).[5]

4. States would have access to a source of valuable outcomes data for patients being treated in FQBHCs. Currently, many States lack whole health (physical and behavioral health) outcomes data from mental health and addictions providers regarding key quality metrics that would help States determine the value of the services provided.

**Second, it would be helpful for States if community mental health centers were included in the HITECH Act**. In order for States to successfully audit providers, ensure that outcomes are being tracked on all persons served, and evaluate the value of care received for its citizens, the providers it contracts with need to have access to electronic health records, data information exchanges, and other 21st century technology tools. With most CMHCs serving a high number of Medicaid clients, their operational budgets have very slim margins and, consequently, many have not been able to keep pace with the technological advancements of the digital age. Within the current financial environment, most States lack funds to support providers to adopt electronic health records and submit data electronically. Thus, this impedes States being able to hold providers accountable for adopting Health IT. Inclusion of community mental health centers in the HITECH Act would be very valuable—especially given the health risks and health costs of the highly fragile populations that they serve.

*Question 2.* Centerstone of Tennessee sees approximately 50,000 patients per year at various facilities and locations. How do your multiple partnerships in the community impact outcomes and are these partnerships effective?

Answer 2. Our community partnerships work and are, moreover, key to our success in impacting outcomes for the people we serve. Centerstone actively partners—depending on the community needs and resources available in its counties—with law enforcement, jails, courts, hospital emergency departments, physician groups, local NAMI and Mental Health America chapters, K–12 public schools, day care agencies, preschools, faith-based organizations, universities, researchers, and other local and regional non-profit organizations. We believe that these partnerships are fundamental and, as such, strengthen our success and program outcomes. We strive to be the community partner of choice.

Without our partnerships with law enforcement, jails and the court system, our mobile crisis team would not be so successful in preventing unwarranted incarcerations. Without our partnerships with hospital emergency departments, physicians, community leaders and parent support groups, our mobile crisis team would not be as successful in preventing unnecessary hospitalizations or worse, tragedies. Without partnerships with preschool administrators and their teachers, our school-based services team would not be successful in providing early assessment and intervention. These early prevention, assessment and intervention programs also importantly enhance the likelihood of a child's future academic success. Without partnerships with teachers and principals, we couldn't teach techniques to help teachers and students prevent bullying, violence, drug use and teen pregnancy. More simply, without these community partnerships and collaborations, there would be more suspensions and expulsions, and we wouldn't be part of Tennessee's rapid success in increasing high school graduation rates.

Our mobile crisis teams would also be less effective if there were not a community relationship in place. For example: an emergency department physician could sign a certificate of need (emergency/involuntary commitment papers for hospitalization) before our staff had an opportunity to engage the patient and complete a full crisis assessment. When provided the opportunity to conduct a face to face assessment, we can typically prevent 50 percent of those encounters from resulting in a psychiatric hospitalization.

Mutual need often defines our community relationship with local law enforcement agencies. We depend on them to help us be safe when we respond to address a crisis. Likewise, they sometimes need us when they respond to a call that requires mental health expertise. Our staff is specifically trained to intervene with people in acute psychiatric crisis. This can be crisis mitigating and life saving.

In our communities that have long-standing preschool advisory boards, the partnerships are very effective. These boards include representation from healthcare providers, child welfare, schools, local charitable agencies, and mental healthcare providers. In our new early childhood system of care communities, these relationships are now being formed, and a governance entity with diverse representation

[5] Cummings JR, Wen H, & Druss BG (2013). Improving access to mental health services for youth in the United States. *Journal of the American Medical Association*. 309(6): 553–54.

is being established. In communities where there is a formal advisory board with diverse representation that focuses on infant and early childhood services, we have found that there are more cross-referrals and communication among service providers which results in better outcomes.

With regard to mental health services within schools, both Centerstone and many of our local school systems are working toward the same goal—for the child and the family to be successful and functioning. The school approaches this from an academic perspective, and we focus on it from a mental health perspective. Both of these perspectives are important and make for a strong, successful relationship. As part of these partnerships, we provide behavioral health services in the school, participate on committees alongside school staff, and provide specialized mental health and addictions trainings for the school staff that they might not otherwise receive. We provide coaching to parents, teachers and administrators, empowering them to successfully address behavioral health concerns—from disruptive behavior in the classroom to self-injurious behaviors.

We also have several unconventional community partnerships. One such example is with Rocketown—a recreational safe place for adolescents in Nashville. We have partnered with them for 3 years, bringing counseling and case management to that environment in a very unique way. We have counselors there in the afternoons, interacting with the staff and intervening with the teens. By being there in the teen's environment, we are seen as a member of the Rocketown team, not as an outsider. While in other settings, it can sometimes be the parent or teacher pushing the teen toward services, but at Rocketown the teens are seeking out services for themselves. Being able to access a respectful, trusting adult can be life-altering for many of these teens. Recently, we helped a child who had been living in a car for several weeks. We helped that child get connected with a respite foster care placement, long-term counseling, and other services the child desperately needed.

Finally, our community success also relies very heavily on our relationships with the many different departments of State government within Tennessee, including the Departments of Health, Mental Health and Substance Abuse Services; Corrections, and the Department of Children's Services. For example, the Tennessee State Department of Mental Health and Substance Abuse Services, under the leadership of Commissioner Doug Varney, has worked with us and other Tennessee mental health agencies to standardize how our mobile crisis teams function and to determine what data we collect. These data have helped the State make decisions regarding the most impactful places for mobile crisis services to be offered. We also work very closely with the Department of Children's Services. Our school-based services use the same outcomes metrics used by DCS. This common outcomes platform helps ensure the success of children in State custody and provides the State with valuable performance information on its provider network.

SENATOR MIKULSKI

*Question 1.* Is any further action needed on the part of Congress to help you offer mental health and substance abuse services in schools?

Answer 1. School-based mental health counselors who provide early intervention, prevention services, treatment resources, development of peer natural helpers, and coordination of care with other health providers have been tremendously effective resources for all children and youth, including high-risk age groups. School-based services eliminate the barrier that families, including working single parents, often have trying to address care for their children with behavioral health needs. Without these services, many children would not be able to obtain the care they seriously need. Many of the children served by school-based services have experienced significant trauma, have neurological conditions that require teachers and other caregivers to get special training and/or coaching, and are at risk for failing academically. Sadly, there is a lack of adequate resources for these evidence-based programs. Fortunately, the Mental Health in Schools Act would be helpful to ameliorate this issue.

While Centerstone now provides school-based services in 13 of its 22 counties in Tennessee, this was not the case 10 years ago. Competitive grants initially enabled us to create and then later expand this service. Beginning this program required initial startup funds. The same is true today; those initial funds enable us to create the necessary infrastructure to reach sustainability. As an example: 7 years ago, we received a 3-year grant to provide school-based services in Montgomery County, TN. While the initial grant was to help support the services of six staff over the 3 years, once we were able to establish the infrastructure and the teachers and administrators realized the value of our services, we were able to expand services. We currently have 22 school-based staff serving in the Montgomery county schools, pro-

viding unique access and care for hundreds of children and adolescents who might not otherwise be accessing treatment.

*Question 2.* What recommendations do you have for improving access to services for families with infants and toddlers who are at risk for emotional problems?

Answer 2. There are several things that could be helpful to improve access to services for families with infants and toddlers at risk for emotional problems. Research has shown the effectiveness of early childhood interventions.[6]

First of all, it would be helpful if every State's Medicaid program could fully implement the Early Periodic Screening Diagnosis and Treatment (EPSDT) benefit to improve the mental health of low-income children and adolescents. Additionally, we recommend that emphasis on Social Emotional development should be included in the EPSDT Program with a procedure for additional mental health assessment when delays are noted.

Additionally, it would be helpful for there to be several key reimbursement changes related to funding for services for this vulnerable population. These include:

- Change the definition of medical necessity for CMS services to include early childhood intervention services;
- Providing reimbursement for CMHCs (or FQBHCs if the definition exists) to provide consultation in hospital settings like the Neo-natal Intensive Care Unit and the Intensive Care Unit. It would be helpful for child psychiatrists, mental health nurse practitioners, psychiatric case managers, and/or therapists from outside community settings to be able to meet with, identify and ultimately intervene with high-risk children and their families;
- Ensuring that CMS compensates providers for providing home visiting services through maternal, infant and early childhood Home Visiting. We have had excellent results in the counties where we provide these services, and it would be wonderful to be able to expand and sustain these services;
- Reimbursement for services in the home setting. Many caregivers and their infants and young children are not able to get to clinics for therapy services. We recommend that there be more emphasis on providing these services in the home setting;
- Reimbursement for maternal, infant, and early childhood parenting classes, especially for at-risk parents with mental health and addiction diagnoses, have been proven to have excellent outcomes in other countries. It would be helpful to enable CMHCs to be able to provide these services; and
- Currently, the trainings that we provide in the community are, by and large, uncompensated. It would be wonderful to have trainings related to early childhood mental health screenings incorporated into the requirements for school, head start, daycare and preschool workers. This would help us to be able to intervene earlier.

It would be helpful for CMS to specifically State that the Diagnostic Classification of Mental Health Disorders of Infancy and Early Childhood (DC: 0–3R) be accepted by States as an acceptable system for diagnosing infants and young children. The DC–0–3R defines disorders as they appear in infants and preschoolers. Several States have developed crosswalks between the DC: 0–3R and the DSM IV.

Last, mental health education programs (i.e., schools of social work or counseling) should offer training in Infant and Early Childhood Mental Health. This is currently not widely available for clinicians, and it should be made more available for student therapists who will be working with infants, toddlers and their families.

SENATOR CASEY

*Question 1.* In your testimony, you noted that 50 percent of mental illnesses start before the age of 14. By what age is it usually possible for professionals to diagnose some of the more common mental illnesses? Can these diagnoses be made by the child's pediatrician, or do they require referral to a specialist following the parent or pediatrician realizing there is a more serious problem?

Answer 1. By using the Diagnostic Classification of Mental Health Disorders of Infancy and Early Childhood (DC: 0–3R) manual, disorders can be identified as early as birth. This classification system includes assessment of the family in addition to individual child characteristics. Most pediatricians have not received training in the DC: 0–3R. It depends on the diagnosis, but around 25 percent of lifetime mental illnesses can be identified by school age.[8]

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[6] National Research Council. (2009). Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities. Washington, DC: The National Academis Press, 2009.

[8] *http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2807642/*.

While some childhood behavioral health diagnoses may be initially identified by pediatricians, it is most helpful if the pediatrician provides a referral for a behavioral health specialist (whether a child psychiatrist or a doctoral or masters-level trained mental health clinician) to conduct a more in-depth assessment. For example, ADHD-like behaviors in a child can be a sign of something else (parental depression, dietary issues, abuse at home, need for parenting training, exposure to trauma), but ruling these out requires a full psycho-social assessment, preferably in the child's home or school environment. Pediatricians often lack the time and training for these in-depth assessments, and the risk of prescribing an ineffective medication to a child that could have harmful side effects is very real. Additionally, if there is not a referral to a specialist, the child often does not receive access to a broader toolkit of treatment options. A pediatrician may only have medication as an option to address disruptive child behavior. A behavioral health provider, if they are offering a full continuum of research-based services for children, will have multiple, highly effective options.

It is critical to intervene as early as possible when there are signs of potential mental health or substance use issues in children and youth. Later intervention decreases good outcomes. In early childhood, a number of issues are closely tied to the adults in a family so intervention for the child often needs to be accompanied by or preceded by intervention for the adults. We believe a significant role for the child's pediatrician as well as other adults who come into contact with a child is to identify the problem or symptom and then to refer to a mental health professional. Attention also needs to be given to over-diagnosis and excessive medication usage [9] in the children's population, particularly the youngest patients.[10]

*Question 2.* You mentioned that Centerstone has been able to offer mental health and substance abuse services within rural schools for children and youth. How common is it for community mental health centers to coordinate their efforts with teachers, schools, day care, or early learning programs? Do you feel that these individuals and institutions have the training and resources needed to help community mental health centers identify and treat mental illnesses early?

According to a report published last month by the *Journal of the American Medical Association*, only ⅓ of rural counties and 63 percent of all U.S. counties having "at least one mental health facility with any special programs for youth with severe emotional disturbance" (Cummings, Wen & Druss, 2013, 553).[11] In a brief review of PubMed, my staff was not able to find specific information previously published regarding the specific question of how common it is for CMHCs to coordinate efforts with these different community partners. In order to address this need, we created a brief survey for providers to complete. This was distributed via e-mail to members of the National Council for Community Behavioral Healthcare and the National Association for City and County Behavioral Health and Developmental Disability Directors.

This survey was completed by 173 different community mental health centers serving 941 counties in 43 States. Here are the results:

| K–12 Schools | Preschools/Early Learning Programs | In-home early intervention (ages 0–4) | In-home services (5–18) | Day Care Settings |
|---|---|---|---|---|
| 145 | 89 | 84 | 129 | 48 |
| 84% | 51% | 49% | 75% | 28% |

As you can see, of the providers that responded to this survey, there is great diversity regarding the services offered and the locations in which they are provided. Only half of the respondents provide early intervention services in the child's home or in preschools or in early learning programs. Only ¼ provide services within day care settings.

Regarding the question of whether non mental health workers within these settings currently have the training and resources needed to help identify and treat mental illness early, the answer is largely no. There is much work to be done in the area of training for early childhood workers in their ability to adequately conduct screening and referrals to appropriate services. In our experience, we have

[9] *http://www.nytimes.com/2009/12/12/health/12medicaid.html?pagewanted=all&_r=0.*

[10] http://psychcentral.com/news/2012/08/15/big-jump-in-antipsychotic-drugs-prescribed-for-kids/43099.html.

[11] Cummings JR, Wen H, & Druss BG (2013). Improving access to mental health services for youth in the United States. *Journal of the American Medical Association*. 309(6): 553–54.

found that staff in these settings are hungry for this knowledge and make excellent use of the training and resources once they receive them.

*Question 3.* You noted that disruption of care can be a concern for young adults if their State Medicaid plan does not allow for an "aging out" transition plan to enable them to seek other health insurance or a new provider in a timely fashion. How damaging can this be to the progress that has been made with treating their mental health problems? Are there any notable examples you can provide where this was an issue?

Centerstone, like many providers, struggles to provide the best care possible to this population. We often will keep teens that have aged out a little longer in our child-based services because they can get lost going into the adult care world and need more contact than the typical adult patient. They've gone from a very structured place in school with a lot of people checking in on them, to having to handle everything on their own. Sadly, with budget cuts, providing these largely unreimbursed additional services are tricky to navigate.

We believe that grants and funding streams to work with this population would be very helpful. Often times, even a couple of months after we transition services, teens that we've helped get stable on their medications and in educational settings drop out of care and relapse. We need a different way to transition these youth. It would be especially helpful if we could provide comprehensive continuity of care programs for young adults with developmental disorders including autism spectrum disorders and serious mental illness. Being in a State still contemplating Medicaid expansion currently makes transition funding difficult. There is a delay time for our State safety net dollars to kick in, and there are years of delay for a teen to qualify for disability. From our experience and from the research, we know that if these teens and young adults could get the right care and have a seamless transition, many wouldn't need disability. However, we also know that if a young adult goes several years without needed medications and treatment, this can have devastating, long-term consequences. Continuity of care would be helpful to address this.

When we asked our staff to provide stories of clients who were damaged by the transition process, we received too many to share in this format. We have selected the stories of these two young people below. All of these young adults needed significant help in making the transition from high school into adulthood that we were not able to provide to them. These summaries were written by staff who worked with these clients, and we have kept them in their own voice.

> "DE–19 years old (at the time she lost her insurance) with a diagnosis of Major Depression Recurrent. She received therapy, case management and medication management services from us. We were actively providing services when she lost her Tenncare. We attempted to appeal and were unsuccessful. We attempted to try and support her after she lost her insurance. She was arrested a few months after we had to transitioned out of services. She lost her temper (her depression manifested itself as irritability and anger) and got into a "fight" with a family member, and the police were called. I still feel that the incident could have been avoided if she could have remained on her medications."
>
> "MT–19 years old (when he contacted us to request services again) with a diagnosis of ADHD and intermittent explosive disorder when he was initially discharged. He called because he was having trouble keeping a job because of his anger, and he had been put out of his mom's home. When we attempted to reopen him, we learned he had lost his insurance. We attempted to help him get his insurance set up again, but we were not successful. He was not able to make all the appointments, and we could not send a staff to walk him through the safety-net process. We attempted to provide him with resources that could help."

SENATOR ENZI

*Question 1.* What can be done to educate local communities about identifying risk factors for mental illness and substance abuse? How do we improve access to treatment? What is working and what is not working?

Answer 1.

*Educating Local Communities*

**The Mental Health First Aid** bill would be helpful to address the need to educate local communities. Mental Health First Aid is specifically tailored to educate local key stakeholders to identify risk factors for Mental illness and Substance Use Disorders. It would be extremely helpful if CMHCs could have access to funding to train law enforcement, hospital emergency departments, local civic and social service organizations, and other community partners. As a recognized service provider

Centerstone already has relationships with many of these entities and this would be a wonderful service addition to these important community relationships.

*Improving Access to Treatment*

While education regarding the importance of treatment is important, it is not effective if there is not access to treatment. There are multiple issues contributing to the overall lack of access to behavioral health services. These include, but are not limited to: lack of transportation, workforce shortages, lack of a specialized workforce, limited use of technology by providers, and funding shortages. Currently, many individuals who are poor and over age 18 have limited access to treatment until they are classified disabled for their condition. This is unfortunate since most people with mental illness—if they receive the right care at the right time—don't have to experience their condition as a life-altering disability. Having a system of FQBHCs, as is proposed under the Excellence in Mental Health Act, would provide that safety net of care for uninsured and underinsured individuals and families—significantly improving access to care.

*What is Working and Not Working?*

While it is a significant undertaking to improve access to mental health and addictions treatment, for everyone in need, we believe another huge challenge is improving access to cost **effective treatment and efficacious care**. This is one of the reasons we are pleased that the Excellence in Mental Health Act specifically mandates providers to use the best evidence-based treatments where available. Lack of effective treatments is a challenge in urban and suburban areas as much as rural areas. You can see the consequences of people receiving poor and/or inadequate care in urban settings as you walk to work. As Dr. Bickman, a researcher we have worked with at Vanderbilt University, recently highlighted in an op-ed in the Tennessean (February 12, 2013), "ineffective treatment is a quieter and unacknowledged crisis that is more pervasive and insidious than insufficient access."

The good news is that mental health and addictions treatment, if done well under the right conditions, has been shown to be extremely effective with positive, long-lasting effects that yield enormous improvements for families, local communities and society in general. However, many providers in the mental health sphere do not currently (1) ensure that only evidence-based treatments are used and (2) have mechanisms in place to ensure that their treatments are resulting in positive outcomes as a result of treatment.

In his article, Bickman proposes seven steps that he believes research shows would fix the "quality problem" in the mental health system. They are:

- "Monitoring the quality of services to ensure they are working.
- Holding service providers accountable for well-implemented evidence-based treatments that show positive outcomes.
- Integrating mental health and primary care following a public health model.
- Eliminating services and practices that do not benefit clients and that hamper the best efforts of underfunded agencies.
- Improving client and family engagement to lower the high client dropout rate in treatment.
- Providing improved education and training so the workforce is more capable of adopting modern technological approaches.
- Providing financial incentives to agencies for delivering effective services."

We support all of these steps, and we believe that the Excellence in Mental Health Act would go a long way to enabling these changes to occur.

We also want to emphasize that improving the effectiveness of care will be impossible without Health Information Technology. It is nearly impossible for providers without Health IT to track outcomes for individual patients and assess fidelity to evidence-based practices. Lacking providers with Health IT capacity, some States have to, unfortunately, make outcomes value decisions based on intermittent paper surveys dependent on a small percentage of the total patient population served. The efforts that Senator Whitehouse has championed regarding expanding coverage for Behavioral Health providers to be included in the HITECH Act are foundational to set up a different U.S. mental health system.

*Question 2.* Can educators, whether in primary schools, secondary schools or universities, be trained to identify at-risk children and adolescents? What are some important strategies for mental health first-aid? How can we ensure students and employees follow through with screenings and treatments for mental health and substance abuse?

*Training Educators*

We have found in our school-based work that educators can definitely be trained to identify at-risk children and adolescents. Oftentimes, educators have no difficulty identifying those children who are acting out. However, it often takes training to help them learn to identify children and adolescents that may be internalizing trauma or may be depressed or suicidal. Trainings for school staff have been invaluable toward helping us all work together for earlier identification of issues. In order to strengthen the education system, we believe that it would be valuable for teacher training programs and continuing education programs to include basic training in early identification.

*Strategies for Mental Health First Aid*

We believe that it is important for key community leaders to receive training in Mental Health First Aid. It can be incredibly helpful to train law enforcement, first responders, emergency department personnel, faith community leaders, local business and civic leaders, and other community partners. While some community organizations have the ability to pay for this training themselves, others lack the funds to do so. We support comprehensive Mental Health First Aid legislation that will assist us in providing this valuable training more broadly in the community. In our experience, the more individuals trained in a community to recognize early warning signs and refer to effective treatment, the more tragedies we can prevent.

*Ensuring Follow-Through With Screenings and Treatment*

Regretfully, due to the complicated current legal system, we cannot offer absolute assurance that students and employees will follow through with screenings and treatment for mental health and substance abuse. In order to address the current gaps in the system, it is most likely that some privacy laws would need to be reviewed.

We do believe that it would be helpful if the common metrics for health care service provision that managed care companies and States were incentivized for achieving (i.e. from NCQA) included metrics for mental health care follow-through and client engagement in services. At Centerstone, we have adopted the NCQA HEDIS metric for client engagement as an outcome across all of our programs and services. Our attention to engagement has helped us have a 44 percent average engagement rate for 2012. Unfortunately, there is not a national metric regarding engagement for mental health services, but the substance abuse client engagement industry average was 15 percent in 2015.[7] There is currently no incentive for achieving excellence in this metric within the mental health services delivery system, besides addictions. However, we believe that if there were an incentive, more providers would improve their client engagement and follow-through. Lack of engagement and follow-through with persons with addictions and serious mental illnesses can have costly, devastating consequences.

We encourage our employees to be creative in helping to ensure follow-through. Our mobile crisis staff is able to go to wherever the need is—at a workplace, school, home, hospital, or other setting—to perform the initial screening. Our school-based staff is able to go into homes, workplaces, or wherever the parent wishes to meet in order to get the parental consent that is required for screening and any follow-up.

One thing that would be helpful to increase screenings is to ensure that school personnel (teachers, administrators, and school resource officers) receive training in mental health and addiction warning signs and how to take appropriate actions to intervene with high-risk children and youth who are exhibiting troubling behaviors. The Mental Health First Aid bill could be helpful to achieve this aim.

[7] *http://www.ghc.org/about_gh/Quality/hedis–2012.pdf.*

COLORADO BEHAVIORAL HEALTHCARE COUNCIL (CBHC),
DENVER, CO.

KATHLEEN C. LAIRD,
*Majority Health Policy Office.*

Hon. TOM HARKIN,
*Committee on Health, Education, Labor, and Pensions,*
*U.S. Senate,*
*Washington, DC 20510.*

MS. LAIRD: Thank you for the opportunity to respond to the Senator's questions. It is a privilege to share my thoughts on their questions. I am inspired by the fact that members of the committee are genuinely interested in how to help people who have mental health and substance use disorder conditions.

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RESPONSE BY GEORGE DELGROSSO TO QUESTIONS OF SENATOR ALEXANDER, SENATOR ENZI, AND SENATOR CASEY

SENATOR ALEXANDER

*Question.* I'm interested in making things easier for States as they tackle the mental health and substance abuse problems facing individuals and families in their communities. What are one or two things the Federal Government can do to make the money we now spend easier to use and help States in this effort?

Answer.

*Payment*

• The main way that the State of Colorado interacts with the Federal Government as it relates to mental health issues is through annual plans that it submits for use of the Federal Government mental health and substance abuse prevention and treatment block grants from SAMHSA, Medicaid, and Medicare. The block grants are important programs that fund a range of critical prevention and treatment efforts around the country for people who do not have health insurance coverage or are under-insured for mental health and substance use disorder coverage.

Unfortunately, the amount of funding available to each State from the block grants is very low. This creates a significant burden on the States to try and cover this need. What I have noticed is that with reductions in State spending for mental health and substance use disorder treatment is one of the first places that cuts are made when what is needed most is increased investment in treatment services. Not receiving necessary treatment results in more burdens on emergency rooms, law enforcement, homelessness, and suicide. In worse case scenarios we see more violence toward other people.

*Congress can help in this area by allocating more money to the block grants to fund additional evidence-based programs that meet communities' needs.*

• Medicaid is an important program for people with mental health and substance use disorders. Each State has their own plan on what they will cover in this area and how they reimburse for services. As the Medicaid coverage expansion rolls out in 2014, more people than ever before will need mental health and addiction services.

*Congress can help by changing the way treatment providers are paid through Medicaid. Currently in most States' payment rates don't cover the cost of care. Creating a Federal definition and status for Federally Qualified Behavioral Health Centers and allowing those entities access to the cost-based reimbursement and mandatory Medicaid status that other safety net providers currently receive (as outlined in the Excellence in Mental Health Act, S. 274) will go a long way toward creating that much-needed expansion of our treatment capacity.*

*Support Integrated Care*

Research indicates an integrated mental health and substance use disorder system, and also integrating care between these two areas and physical health care will reduce cost, increase health outcomes, and improve access to necessary care. The rules, regulations, and payment models in SAMHSA, Medicaid, and Medicare are not aligned together to support integrated service delivery at the local level. This misalignment creates excess burden on States and providers to try and integrate care.

*Congress can help in this area by requiring Federal Agencies to align their efforts to develop and implement rules, regulations, and payment methodologies that are conducive to integration of health care.*

SENATOR CASEY

Thank you for your explanation of Mental Health First Aid and the valuable role it can play in identifying individuals with mental illness and referring them to appropriate care.

*Question 1.* How long did it take Colorado to establish its Mental Health First Aid training program?

Answer 1. MHFA came to Colorado in 2009, starting with just a handful of Instructors participating in the original U.S. pilot. Since then, the Colorado Behavioral Healthcare Council, the Colorado Office of Behavioral Health, and the statewide network of community mental health centers have spearheaded an effort to rollout the program statewide. In 2013, our Instructor network will eclipse 200, delivering both the adult and youth Mental Health First Aid curricula, as our State rapidly approaches the 10,000 mark for Mental Health First Aiders certified.

*Question 2.* What is the cost to provide Mental Health First Aid training?

Answer 2. There are three primary costs associated with Mental Health First Aid that we have encountered.

(1) Training Mental Health First Aid Instructors (those who will deliver the courses in the community) is about $1,500 per Instructor;

(2) Cost to actually deliver the course in the community (participant manuals, training materials, etc.) is $20–25 per participant, up to 30 participants per course; and

(3) Implementation supports to facilitate program dissemination (infrastructure, coordination, promotion, ongoing evaluation, etc.) should be considered. We are happy to provide the estimated amount needed in Colorado, but this would vary across the country.

*Question 3.* Is the program designed in such a way that it could be easily scaled up. I'm interested in making things easier for States as they tackle the mental health and substance abuse problems facing individuals and families in their communities.

Answer 3. Yes—This is a health education and primary prevention program that has the potential to reach a huge population; linking people to care, combating stigma, and enhancing mental health and substance abuse literacy. Colorado has been able to grow the program considerably in a short amount of time and with limited resources, and with additional support could expand our efforts exponentially. It is important to note that investment in implementation supports is critical, as is the case when attempting to take any evidence-based program to scale. Having an advisory committee that represents a wide range of stakeholders also helps to ensure that expansion keeps a bigger vision than just reaching to one or two specific populations. The media also is interested in MHFA and its potential. Several reporters and news agencies have been involved in our efforts.

SENATOR ENZI

*Question.* What can be done to educate local communities about identifying risk factors for mental illness and substance abuse? How do we improve access to treatment? What is working and what is not working?

Answer.

*Education*

In Colorado we have engaged in a statewide approach to community education about mental illness and substance use disorder. Our Community Mental Health Centers have a very large investment in Mental Health First Aid training. Our State Office of Behavioral Health has also provided some funding to aid in this effort. We work collaboratively with a broad cross-section of Coloradoans to deliver Mental Health First Aid (MHFA), including law enforcement, schools, and the faith community.

Mental Health First Aid is a public education program that can help families, communities, educators, law enforcement, primary care providers and others to understand mental illnesses, seek timely intervention, and save lives. MHFA teaches a five-step action plan to help people recognize the symptoms of common mental illnesses and addiction disorders; de-escalate crisis situations safely; encourage appropriate self-help strategies, and initiate timely referral to mental health and substance abuse resources available in the community.

*Congress can help by supporting the Mental Health First Aid Act that has been introduced by Senator Begich with bipartisan support. This bill authorizes $20 million for training Americans in MHFA to improve community education about mental illness and help people get access to treatment.*

*Improving Access to Treatment*

There are many areas to address to improve access to treatment. Each State and local community will need to address the following:

*Adequate Coverage*: It is important to ensure that public programs and private insurance adequately cover mental health and substance use disorder treatment. Parity with primary health care is essential.

*Payment Reform*: Mental health and substance use services need to be paid a fair rate that covers the cost of prevention, intervention, treatment and aftercare services. It is important to reimburse mental health, substance use, and primary care providers for the services they provide.

*Work Force Development*: There is a severe shortage of mental health and substance use disorder providers, particularly in rural areas and in specialties such as child psychiatry. Loan forgiveness programs seem to help rural areas attract providers. It is important for colleges and universities to provide areas of study for a workforce that will work in mental health and substance use disorder care. Today's workforce may need credentialing in both mental health and substance use disorder and to provide care in primary health care settings. Payment reform will also help attract people to this area of health care. Salaries and benefits for providers have been historically low compared to people who have similar skills and qualifications.

*Use of Technology*: There is great potential to provide mental health and substance use disorder care thru tele-video and using Web-based tools. This will increase access of services in rural and frontier communities. Plus increase access to specialists, such as child psychiatrists and treatment for autism. Some of this care will also be provided across State lines. Rules and regulations need to be in place to ensure providers can provide care using tele-health beyond the usual borders, and to be reimbursed fairly. Some level of regulation and credentialing of providers who do care over the Internet and standards for compliant connections between providers and patients need to be addressed.

*What is Working and Not Working*

*Integrated Care*: It is essential that providers provide care with the whole person in mind. Historically, mental health and substance use disorder care has been separated from physical health. Evidence clearly indicates that if a person has both mental health and substance use disorder needs, plus the person has physical health problems they have a better chance of recovery at a lower cost if all of their health care services are addressed together. Mental health and substance use disorder providers need to integrate more physical health services, data, and information into their provision of care, and physical health providers need to do the same with mental health and substance use disorder.

*Managed Care*: Colorado's Medicaid mental health program has been using managed care since 1995. This program is a full-risk contract. The results have been significantly better than a fee for service payment model. Access to services has improved, more care is being provided in a person's home community, and millions of dollars have been saved. A key ingredient to Colorado's success is the opportunity for providers and managed care companies to partner together and share risk. Models that include risk sharing for both service delivery and health outcomes have significant promise to improve health care and reduce costs.

*Prevention and early intervention*: Most of the funding for mental health and substance use disorder is for treatment. This treatment is usually provided after a person already has a diagnosed condition. Many of these conditions could have been avoided, have less negative impact if they had been identified earlier or prevented. Services provided at earlier stages are less expensive than higher level care, such as hospitalization. It is important to add prevention and early intervention services for mental health and substance use disorder in public programs and private insurance.

*Evidence-based care*: There are a growing number of mental health and substance use disorder interventions and treatments that predict better outcomes. Providers and payers need to focus on delivering and paying for services that have the best chance to improve a person's overall health. It is important to focus on the person's outcome of treatment than the number of services provided. This will require the ability to collect data on a person's progress, and use that information in treatment.

Sincerely,

GEORGE DELGROSSO,
*CEO, CBHC.*

RESPONSE BY LARRY FRICKS TO QUESTIONS OF SENATOR ALEXANDER, SENATOR MIKULSKI, SENATOR ENZI, AND SENATOR CASEY

SENATOR ALEXANDER

*Question 1.* I'm interested in making things easier for States as they tackle the mental health and substance abuse problems facing individuals and families in their communities. What are one or two things the Federal Government can do to make the money we now spend easier to use and help States in this effort?

Answer 1. I think the most important thing the Federal Government can do through existing programs is to establish Federally Qualified Behavioral Health Centers in Medicaid. By putting a definition of these entities into Federal law, consumers will be assured when they seek care at an FQBHC, that center offers a
comprehensive range of high-quality mental health and addiction treatment services. Without a definition, there are currently no standards of care and no way to guarantee that all Americans have access to the full range of needed services regardless of where they live. The Federal Government can also encourage States to do more to make use of peer support services in their Medicaid programs.

*Question 2.* You have experienced the mental health system from many different perspectives. What are some of the biggest challenges you've experienced?

Answer 2. As I mentioned in my testimony, stigma remains a huge barrier to people accessing needed mental health services. One of the biggest challenges is the ongoing discrimination that people with a mental health issue face. We have come a long way in raising public awareness of mental illness and addictions and educating people about how to reach out and support someone living with these conditions, but there is still a long way to go. The Mental Health First Aid Act (S. 153) is one way that we can help erase stigma. Another important thing we can do is improve access to peer services and supports, which were vital in my own recovery experience. Peer specialists are trained in skills to promote strength-based recovery and whole health, delivering services that are Medicaid billable when included in State plans. CMS considers them an evidence-based practice, but too many States either don't offer peer services through Medicaid or impose stringent medical necessity criteria on them that make it difficult for individuals to have access to peer specialists through Medicaid.

SENATOR MIKULSKI

*Question.* Do either the substance abuse prevention and treatment block grant or community mental health services block grant need reform to best meet the needs of patients in our communities?

Answer. The block grants are important programs that fund a range of critical prevention and treatment efforts around the country. I would not say that the block grants need "reform"—rather, what is needed most is increased investment in treatment services. There are two ways this can happen: (1) by allocating more money to the block grants to fund additional evidence-based programs that meet communities' needs; and (2) by changing the way that we reimburse treatment providers through Medicaid. As the Medicaid coverage expansion rolls out in 2014, more people than ever before will need mental health and addiction services. Right now, the community behavioral health system is already overburdened and struggling with payment rates that don't cover the cost of care. Creating a Federal definition and status for Federally Qualified Behavioral Health Centers and allowing those entities access to the cost-based reimbursement and mandatory Medicaid status that other safety net providers currently receive (as outlined in the Excellence in Mental Health Act, S. 274) will go a long way toward creating that much-needed expansion of our treatment capacity.

SENATOR CASEY

*Question.* What kind of barriers did you encounter while attempting to find employment when you were struggling with your mental illness? Is there a role for private employers to play in helping those with mental illness? If so, what do you think is the best way to reach out to them?

Answer. Yes, there is absolutely a role for private employers to play. One important thing they can do is to ensure they offer health insurance that includes adequate coverage of mental health and substance use conditions. A barrier to people who have been on disability because of behavioral health conditions re-entering the workforce, is uncertainty about whether they will continue to have healthcare coverage that meets their needs. Employers should look at the scope of coverage they

offer to make sure it is comprehensive and inclusive of the needs of people with mental illness.

SENATOR ENZI

*Question.* What can be done to educate local communities about identifying risk factors for mental illness and substance abuse? How do we improve access to treatment? What is working and what is not working?

Answer. Educating local communities about mental illness and substance abuse is extremely important. The symptoms of severe mental illness often emerge slowly and can be difficult to detect without basic information on what to look for. Even when friends and family of someone who appears to be developing mental illness can tell that something is amiss, they may not know how to intervene or direct the person to self-help programs and treatment—which means that all too often, those in need of mental health services do not get them until it is too late.

Mental Health First Aid is a public education program that can help communities understand mental illnesses, seek timely intervention, and save lives. MHFA teaches a five-step action plan to help people recognize the symptoms of common mental illnesses and addiction disorders; de-escalate crisis situations safely; encourage appropriate self-help strategies, and initiate timely referral to mental health and substance abuse resources available in the community. I am a Mental Health First Aid trainer, which means I teach people how to instruct others in becoming certified Mental Health First Aiders. I have witnessed first-hand the positive impact that comes from people with lived experience of recovery gaining the skills for providing support to help others experience a life of recovery from mental illness and substance abuse. To that end, I would encourage you to support the Mental Health First Aid Act, which authorizes $20 million for training Americans in MHFA to improve community education about mental illness and help people get access to treatment.

[Whereupon, at 12:36 p.m., the hearing was adjourned.]

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