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MENTAL HEALTH AND SUBSTANCE USE DISORDERS IN AMERICA: PRIORITIES, CHALLENGES, AND OPPORTUNITIES

HEARING

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

UNITED STATES SENATE

ONE HUNDRED FOURTEENTH CONGRESS

FIRST SESSION

ON

EXAMINING MENTAL HEALTH AND SUBSTANCE USE DISORDERS IN AMERICA, FOCUSING ON PRIORITIES, CHALLENGES, AND OPPORTUNITIES

OCTOBER 29, 2015

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C O N T E N T S

STATEMENTS

THURSDAY, OCTOBER 29, 2015

MENTAL HEALTH AND SUBSTANCE USE DISORDERS IN AMERICA: PRIORITIES, CHALLENGES, AND OPPORTUNITIES

THURSDAY, OCTOBER 29, 2015

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

The committee met, pursuant to notice, at 10:05 a.m. in room SD–430, Dirksen Senate Office Building, Hon. Lamar Alexander, chairman of the committee, presiding.

Present: Senators Alexander, Isakson Collins, Scott, Cassidy, Murray, Franken, Baldwin, Murphy, and Warren.

OPENING STATEMENT OF SENATOR ALEXANDER

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

Senator Murray is on her way and has suggested that we go ahead. She will be here very shortly. She and I will each have an opening statement, and then we will introduce our panel of witnesses. After our witness testimony, Senators will have 5 minutes of questions.

Today, we are discussing the important issue of mental health and substance use disorders. Mental illness affects a great many Americans. According to a 2013 report from the National Survey of Drug Use and Health, nearly one in five adults over the age of 26 reported suffering from a mental illness. In that same time period, nearly 1 in 10 Americans between the age of 12 and 17 reported having at least one major depressive episode.

In Tennessee, about one in five adults reported having a mental illness in 2013. That is more than a million Tennesseans according to the Tennessee Department of Mental Health and Substance Abuse Services. About 5 percent had a severe mental illness. That is nearly a quarter of a million Tennesseans. About 41,000 Tennesseans had a major depressive episode.

Already, there is an enormous response to try to help at the State level by the private sector and by the Federal Government. As a former Governor, I know firsthand that States have traditionally been on the forefront with their Departments of Mental Health, their treatment facilities, and community-based services.

States have had the primary responsibility for behavioral health and provide community-based programs that often include counseling, case management, social work, and provide screening, diagnosis, and treatment for children.

In the private sector there are many private hospitals, nonprofits, mental health professionals, and others working to help those in need. Efforts from the private sector totaled about $67 billion in 2009 or 39 percent of total dollars spent for behavioral health, which includes mental health and substance use services. Government spending totaled about $105 billion in 2009 or 61 percent of total dollars spent, and that includes Medicare, Medicaid, and other efforts on the local, State, and Federal levels.

One role the Federal Government plays is through its agencies. The Substance Abuse and Mental Health Services Administration is an agency within the U.S. Department of Health and Human Services. Its role in supporting mental health programs is relatively small compared to the responsibility that States have and the role of Medicaid, but it is also critically important.

SAMHSA supports States, behavioral health care providers, and others by improving the availability and quality of prevention and treatment services, collecting behavioral health data, and sharing best practices through evidence-based initiatives. SAMHSA should be looked at as a leader in the field. It receives about $3.5 billion each year through the discretionary appropriations process.

The biggest Government role is the amount of money spent through Medicaid, which is a Federal-State partnership. In 2009, Medicaid spending on behavioral health totaled about $44 billion, 26 percent of total dollars spent. These Medicaid dollars can be used to provide care from community behavioral health professionals, inpatient or residential treatment for children and seniors with mental illness, and help those with severe mental illnesses get the prescription drugs they need.

In Tennessee last year, State spending for mental health and substance use disorder programs and services totaled about $555 million. Two hundred and thirty million of that was spent on the State's share of Medicaid related to mental health. Three hundred and twenty-five million was spent by the State Department of Mental Health.

The Federal Government's Medicare spending also plays a role financing 7 percent of total expenditures to treat mental illness at about $21 billion a year. These Medicaid dollars could help seniors get prescription drugs they need or can be used for doctors' appointments, outpatient therapy, and a small fraction of inpatient treatment for mental health.

This Federal support is a significant amount of money. One question for today is should we be spending these dollars differently? Or should we be spending more dollars, and if so, in what ways?

There are calls for the Federal Government to act differently to help those in need and to do more. Twice, the Senate Health Committee has passed different versions of the Mental Health Awareness and Improvement Act that Senator Murray and I have cosponsored once last Congress and again just last month. This bipartisan legislation supports suicide prevention and intervention programs. It helps train teachers and school personnel to recognize and understand mental illness, works to reduce the stigma against those struggling with mental illness, and helps children recover from traumatic events. I hope the Mental Health Awareness and Im-

provement Act will be passed by the Senate and become law this Congress.

Other Senators are also tackling the issue of how to improve mental health treatment. Senators Cassidy and Murphy have a mental health bill they introduced in August. Senator Franken has introduced a couple of pieces of legislation. Senator Cornyn has a bill that he is working on in the Judiciary Committee.

I expect to see the HELP Committee report additional legislation in the coming months that better supports States in addressing mental health and substance use disorder in their communities. We will see what the Judiciary Committee might be doing, what the Finance Committee might be doing on Medicaid and Medicare and see about putting all those together to better coordinate our response toward mental health.

Today's hearing, though, is really to better understand the Federal Government's role in mental health treatment and how it can help States like Tennessee meet such high need and deliver such critical care.

I am looking forward to hearing from today's witnesses. Are there administrative things we can do, programmatic things? Are we putting up roadblocks? How are our Federal programs working?

I am particularly interested in your thoughts on mental health research. One of the most important things the Federal Government does is research that enables individuals to move forward in this big, complex society of ours. We are not such good managers. Sometimes, we are not even good regulators. The research that we have funded and encouraged has enabled enormous breakthroughs in our country, so I would like your thoughts on the state of mental health research as well.

Senator Murray.

OPENING STATEMENT OF SENATOR MURRAY

Senator MURRAY. Mr. Chairman, thank you so much. Thank you to all of our colleagues who are joining us today, and I especially want to thank the witnesses who are taking time to join us today. Dr. Insel, I especially want to welcome you as you prepare to move on, and thank you for your tremendous amount of work. We all appreciate what you have been able to do and will continue to do, I am sure.

Over the last few years, we have made real progress toward building a health care system that works for our families and communities, and puts their needs first. As I have often said, there is a lot more we can and must do, and this is especially true when it comes to addressing mental health and substance abuse.

Today, nearly 1 in 5 people in our country experience mental illness in a given year. Far too many of them do not receive treatment when they need it. In fact, there is on average nearly a decade between someone showing signs of mental illness and getting treatment. Suicide is the second-highest cause of death for those ages 15 through 34, and nearly a quarter of the State prison population has struggled with mental illness.

These statistics are deeply disturbing, but the stories behind them are even more tragic: a stigma that keeps too many of them from seeking help even though it could make all the difference;

treatable illnesses dealt with by a judge rather than a clinician; millions of lives, especially young lives, that are cut short. All of us have heard these stories far too often and they demand action.

Members of this committee on both sides of the aisle have made clear that improving our mental health system is a priority. In particular, I do appreciate the bipartisan work that Senators Murphy and Cassidy are doing to push for progress. I am looking forward to hearing from my colleagues and our witnesses about the ideas they have to strengthen our mental health system and prevent more of our parents and our friends and our neighbors, students, and children from falling through the cracks.

There are a few challenges I am focused on in particular. Our mental health workforce should serve as the foundation on which a strong, supportive system is built, but today, far too many communities have inadequate access to mental health professionals. In fact, half of all U.S. counties today do not have a single psychiatrist, psychologist, or social worker. That means that for far too many patients and their families, it is unclear to them where they should turn for help.

We need to make sure communities have access to trained professionals who can intervene and treat and support those struggling with mental illness. This is critical to ensuring that mental health is seen as just as much a priority as physical health. Is integrating primary care with mental health care.

Too often, patients' mental and physical health are considered separately, and that silo means that, on the one hand, patients with serious mental health illness who need primary care may not get it when they need it, and on the other hand, that any signs of mental illness may go undetected. That presents a real threat to patients with mental illness, especially those with chronic physical health problems or substance abuse disorders that can make mental illness worse.

I am very interested in a collaborative model being practiced in my home State of Washington where mental health professionals provide telehealth consulting to primary care physicians in communities that lack access to mental health care. That model helps patients receive treatment that is mindful of both their mental and physical health.

As we work to improve detection and treatment of mental illness, we need to prioritize crisis response. I have heard too many stories in my State and across the country of patients with mental illness held for days and weeks in emergency rooms or even solitary confinement waiting for treatment. That is unacceptable. Communities need the resources to respond quickly and appropriately when someone is clearly in or approaching a crisis because without those resources, intervention often comes too late or not at all.

Suicide prevention must be a priority. Each year, suicide takes tens of thousands of lives in our country and shatters countless others. Like many here today, I have been deeply concerned about the high rate of suicide among our veterans.

We also need to take a close look at what is driving those tragic decisions among other populations. I was very concerned to learn, for example, recent studies show young adults from tribal communities are at especially high risk. I know the Administration is very

focused on suicide prevention, and our committee recently passed the Mental Health Awareness and Improvement Act, which reauthorized the critical Garrett Lee Smith Suicide Prevention Act. I look forward to continuing our working together to put an end to this crisis in every one of our communities.

Finally, it is critical to acknowledge that in order to confront the challenges we have talked about and many others within our mental health system, we have to break down the barriers that stigma creates for those suffering from mental illness. That means prioritizing research that helps enhance our understanding of and ability to effectively treat mental illness. It also means raising awareness so those struggling do not feel they have to struggle alone.

I saw the stigma early on when I interned in a VA psychiatric ward when I was a college student. There were veterans returning from the Vietnam War at the time with severe psychological trauma, and they were told they were simply shell-shocked.

Over the course of my career, I have heard time and again from veterans and constituents from all walks of life that stigma and stereotypes are a crushing burden to bear on top of illness. Those struggling with mental illness should be treated with compassion and respect and dignity, and they should have the resources they need to live and work in their communities. That is something that I will continue to be very focused on.

Mr. Chairman, I am very pleased that we are having this discussion today, and I look forward to working with you on a bipartisan basis to strengthen our mental health system and give more patients and families the opportunity to lead healthy, fulfilling lives.

I am confident that everyone in this room has a story about a friend or a loved one or a classmate or a coworker who faced mental illness. The harsh reality is these challenges impact all of us, and I hope our efforts here today are a step on the way to overcoming them.

Thank you again for everyone participating in this.

Mr. Chairman, thank you for holding this hearing, and I look forward to this conversation.

The CHAIRMAN. Thank you, Senator Murray.

This is a subject that has broad interest among members of the committee, as is indicated by the number of Senators here today, and I would say to our committee members, this is yet another bipartisan hearing, which means that Senator Murray and I have agreed on the subject and we have agreed on the witnesses, and we have agreed that this is the best way to get a result. We have had very few partisan hearings during this year, and that has been good for our committee.

I am pleased to welcome three witnesses to our hearing today. First, thanks to each of you for taking the time to be here. You have busy jobs overseeing important agencies.

First, we will hear from Kana Enomoto. Ms. Enomoto is acting administrator of the Substance Abuse and Mental Health Services Administration. That means she oversees four centers, the one for mental health, one for substance abuse prevention, substance abuse treatment, and behavioral health statistics and quality. She has been serving at SAMHSA since 1998 in several positions.

Our second witness is Mr. Jim Macrae. He is acting administrator of the Health Resources and Services Administration, often called HRSA. He joined HRSA in 1992 and has since held several positions. He has received several awards for his service and leadership as a HRSA administrator.

Next, we will hear from Dr. Tom Insel. He is director of the National Institute of Mental Health, which is part of the National Institutes of Health, and leads research related to mental health. He has held that position since 2002. He is focused on genetics and biology of mental disorders. Before that, he was professor of psychiatry at Emory University. He will be leaving his position soon to pursue research outside of NIH, but we appreciate his service, and we especially appreciate his willingness to come here before his departure to tell us, bluntly and in plain English, exactly what we ought to be doing.

[Laughter.]

It is safe to do it now.

[Laughter.]

Senator COLLINS. I think it will be safe to do it in 2 days.

[Laughter.]

The CHAIRMAN. We will begin, Mrs. Enomoto.

STATEMENT OF KANA ENOMOTO, M.A., ACTING ADMINISTRATOR, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, ROCKVILLE, MD

Ms. ENOMOTO. Chairman Alexander, Ranking Member Murray, and members of the committee, thank you so much for holding this hearing on a topic that is critical to the physical, emotional, and economic health of the Nation. Thank you for inviting me to testify today.

It is a great honor to talk to you about the State of America's mental health system, a topic that is very near and dear to my heart, and I would like to discuss with you some of the initiatives of SAMHSA, delivering impact for American people every day.

As my colleague Dr. Insel will also tell you, neuropsychiatric disorders are the leading cause of disability burden in the United States. More than one in four Social Security Disability Insurance recipients are enrolled due to a mental illness, and individuals with serious mental illness, or SMI, make up over 40 percent of those people who are dually eligible for Medicare and Medicaid.

Yet at $147 billion per year in 2009, mental health spending accounted for only 6 percent of health care spending, and substance use spending accounted for only 1 percent. The burden of untreated or undertreated behavioral health conditions on the labor market, criminal justice system, families, schools, communities, and others, is tremendous.

In this context, SAMHSA's mental health budget, approximately $1 billion in 2015, is a small, as noted, but important influencer of the Nation's mental health system. To accomplish our mission, SAMHSA cannot work alone. Therefore, another one of our—a key role is to lead by coordinating mental health services and programs across HHS and with other Federal departments.

One main example of this is that SAMHSA co-chairs the HHS Behavioral Health Coordinating Council, which was established in

2010. The chief goal of that group is to provide a platform for knowledge exchange and then to ensure that behavioral health issues are handled collaboratively and without duplication of effort across the department.

Across Federal Government, SAMHSA works closely with Department of Defense, Education, HUD, Justice, Veterans Affairs, and the Social Security Administration. We work on a wide range of issues spanning prevention, treatment, and recovery support for people with or at risk of mental illness.

To achieve our mission, we administer a combination of competitive and formula grant programs. I will share a few examples. First, the Community Mental Health Services Block Grant is a flexible spending source for State mental health authorities. States use these limited but significant funds, about $500 million, to support planning, administration evaluation, educational activities, and direct service delivery for adults with serious mental illness and children with serious emotional disturbance.

Starting in fiscal year 2014, Congress required States to set aside 5 percent of those funds for evidence-based programs that addressed the needs of individuals with early serious mental illness, including psychotic disorders. These programs are informed by the NIMH RAISE project and similar research, and an initial evaluation tells us that this set-aside funding is helping States increase access to early intervention programs and reduce the duration of untreated psychosis and other psychiatric conditions.

This news is so exciting. The ability to pre-empt long-term disability for hundreds of thousands of young Americans is at our fingertips.

At SAMHSA we also recognize that financing is a central piece of the puzzle. We work closely with our colleagues at CMS and across HHS to align payment systems to encourage high-quality care for adults and children with both mental illnesses and substance use disorders.

Just last week, thanks to Congress's passage of legislation in 2014, SAMHSA was pleased to award section 223 planning grants to 24 States to certify community behavioral health clinics, establish a prospective payment system, and prepare to participate in a 2-year Medicaid demonstration program. The ability to transform the way community services are reimbursed could help us turn the corner on key provider quality and capacity issues.

Youth suicide prevention is also a critical area of focus, and evaluation of the Garrett Lee Smith tribal, State grant program demonstrated that counties with GLS suicide-prevention activities saw lower rates of suicide and suicide attempts.

Unfortunately, too many communities and too many people are unaware of the major public health crisis that we are facing around suicide. While we are making progress in the area of youth suicide, middle-age and older adult suicide continues to climb, and SAMHSA's suicide prevention grants, as currently funded, limit their focus to youth and adolescents. Yet the data show that almost 9 out of 10 people who die by suicide are over age 24. To move the needle, we must expand the scope of our prevention efforts.

As my fellow acting administrator Jim Macrae well knows, no conversation about any aspect of health care can be complete with-

out talking about workforce needs. Together, the Affordable Care Act and the Mental Health Parity and Addiction Equity Act are expected to expand parity protections and coverage of behavioral health services to over 60 million Americans.

Thus, the current infrastructure and workforce will need additional capacity in order to help have space for the people who need treatment who will now begin to seek it. The expanded workforce includes prescribing and non-prescribing professions, including psychiatrists, social workers, counselors, therapists, and peers.

We are grateful to HRSA for its collaboration in the area of behavioral health workforce, we are grateful to the NIMH for its outstanding work in mental health research, and we are thankful to the committee for allowing me to share highlights of SAMHSA's portfolio.

If I may take liberty for just a few more seconds, I would like to dedicate a couple of moments to express appreciation to my colleague Dr. Tom Insel. Tom, you are a powerful leader for our field. You have been steadfast in your vision that mental health research, whether at the level of the genome or the globe, should be of no less rigor or quality than any other field of research. Your commitment to bringing the best science to bear on any policy or program question has been invaluable to SAMHSA.

Thank you for your service. We at SAMHSA stand ready to help you achieve the tenfold impact of your next innovation. Thank you.

[The prepared statement of Ms. Enomoto follows:]

PREPARED STATEMENT OF KANA ENOMOTO, M.A.

Chairman Alexander, Ranking Member Murray, and members of the Senate Health, Education, Labor, and Pensions Committee, thank you for inviting me to testify at this important hearing. I am pleased to testify along with Dr. Insel from the National Institute of Mental Health (NIMH) and Acting Health Resources and Services Administration (HRSA) Administrator Macrae on the state of America's mental health system and, specifically, to discuss some of the Substance Abuse and Mental Health Services Administration's (SAMHSA) initiatives related to mental health. I understand that the committee will be holding a series of hearings on behavioral health issues, including potentially one on the opioid public health crisis; however, this testimony will focus on SAMHSA's roles as it relates to reducing the impact of mental illness on America's communities.

SAMHSA

As you are aware, SAMHSA's 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 to health;
- Prevention works;
- Treatment is effective; and
- People recover.

LEADERSHIP IN COORDINATING MENTAL HEALTH ACTIVITIES

In partnership with the Assistant Secretary for Health, SAMHSA co-chairs the Department of Health and Human Services (HHS) Behavioral Health Coordinating Council (BHCC), which was established in 2010. The Council coordinates behavioral health policy activities within HHS, by facilitating information sharing and collaboration across the Department. Its chief goals are to share information and ensure that all behavioral health issues are handled collaboratively and without duplication of effort across the department. BHCC subcommittees include, but are not limited to Serious Mental Illness, Primary Care/Behavioral Health Integration, and Trauma and Early Interventions.

SAMHSA and NIMH co-chair the Subcommittee on Serious Mental Illness (SMI) charged with improving research, treatment, and supports for Americans with seri-

ous mental illness. The subcommittee has established several goals for the near term to engage people with SMI in treatment especially through early intervention approaches and prevention of mental illness; promoting higher quality of mental health care and medical care to reduce morbidity and mortality with incentives for evidence-based practices and performance measurement; and improving availability of community-based supports and prospects for long-term recovery.

SAMHSA works with a number of other Departments—including the Departments of Defense, Education, Housing and Urban Development, Justice, and Veterans Affairs, as well as the Social Security Administration (SSA)—both directly and through Federal workgroups to promote mental health. For example, SAMHSA leads the Federal Working Group on Suicide Prevention as well as the Federal Partners Committee on Women and Trauma.

PREVALENCE OF BEHAVIORAL HEALTH CONDITIONS AND TREATMENT

It is estimated that almost half of all Americans will experience symptoms of a behavioral health condition—mental illness or substance-use disorder—at some point in their lives. Yet, today, less than one in five children and adolescents with diagnosable mental health problems receive the treatment they need.[1] And according to data from SAMHSA's 2014 National Survey on Drug Use and Health (NSDUH), an estimated 45 percent of the almost 44 million adults with any mental illness and 69 percent of the almost 10 million adults with serious mental illness received mental health services in the past year. Only 11 percent of those with diagnosable substance use disorders receive needed treatment.[2]

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 in regard to early identification by helping communities understand and implement prevention approaches we know can be effective in stopping issues from developing in the first place.

OVERVIEW OF THE NATION'S MENTAL HEALTH SPENDING

According to SAMHSA's *National Expenditures for Mental Health Services & Substance Abuse Treatment 1986–2009*, at $147 billion, mental health spending accounted for 6.3 percent of all health spending in calendar year 2009, while substance use spending at $24 billion accounted for approximately 1 percent.

Although most of the funding for services for people with mental illnesses comes through Federal insurance programs, especially Medicaid, in addition to funding a portion of the Nation's mental health treatment, SAMHSA's programs are also critical in supporting the coordination of services for people with mental illnesses and improving the quality and accessibility of these services and supports.

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[1] Unmet Need for Mental Health Care Among U.S. Children: Variation by Ethnicity and Insurance Status Sheryl H. Kataoka, M.D., M.S.H.S.; Lily Zhang, M.S.; Kenneth B. Wells, M.D., M.P.H., Am J Psychiatry 2002;159:1548–55. 10.1176/appi.ajp.159.9.1548

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

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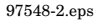
SAMHSA'S BUDGET

In fiscal year 2015, approximately 30 percent of SAMHSA's total funding was appropriated or designated for mental health programs and activities, with the remainder directed to substance use programs and activities. This distribution of funding between substance use and mental health has been consistent for the last 5 years. Of the SAMHSA fiscal year 2015 mental health funding, $1.079 billion supports prevention, treatment and recovery support programs and activities within SAMHSA's Center for Mental Health Services (CMHS). In addition to funding within the CMHS appropriation, approximately $67 million of SAMHSA's Health Surveillance and Program Support (HSPS) appropriation is used for mental health activities.



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EXAMPLES OF SAMHSA PROGRAMS

To inform mental and substance use disorder policy, SAMHSA conducts national surveys and analyses. For example, the National Survey on Drug Use and Health (NSDUH), which SAMHSA administers, serves as the Nation's primary source for information on the incidence and prevalence of substance use and mental disorders and related health conditions. NSDUH provides key data such as the fact that 1 in 10 adolescents (11.4 percent) had a major depressive episode in the past year.[3]

To accomplish its work, SAMHSA administers a combination of competitive programs and formula-based programs, including the two block grant programs. SAMHSA also collects performance and evaluation data to measure impact and mitigate risk. Below are a few examples of SAMHSA mental health programs.

Community Mental Health Services Block Grant (MHBG)

Approximately 45 percent ($482.57 million) of CMHS funding is directed toward the MHBG, which provides services and supports for adults with serious mental illness and children with serious emotional disturbance, an analogous definition of serious mental illness for children. The MHBG is a flexible spending source that supports a range of services, infrastructure, and capacity efforts for State mental health authorities that serve the over seven million individuals affected by these conditions. States use these limited but significant funds to support planning, administration, evaluation, educational activities, and direct service delivery. Services typically include those not covered by Medicaid or other funding sources, such as rehabilitation services, crisis stabilization, case management, supported employment and housing, jail-diversion programs, and services for special populations. By law, States are not allowed to use these funds for inpatient services.

Starting in fiscal year 2014, the Congress—through annual appropriations legislation—required States to set aside 5 percent of their MHBG funds to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders. These programs are informed by the NIMH-supported *Recovery After an Initial Schizophrenia Episode (RAISE)* project and similar research. The majority of individuals with serious mental illness experi-

[3] Substance Abuse and Mental Health Services Administration, *Results from the 2014 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, 2015.

ence their first symptoms during adolescence or early adulthood, and there are often long delays between the initial onset of symptoms and a person receiving treatment. The consequences of delayed treatment can include loss of family and social supports, reduced educational achievement, disruption of employment, substance use, increased hospitalizations, and reduced prospects for long-term recovery.

The 5-percent set-aside equals $24.2 million and is allocated to States consistent with the block grant formula. It supports implementation of promising models that seek to address treatment of serious mental illness at an early stage through reducing symptoms and relapse rates, and preventing deterioration of cognitive function in individuals suffering from psychotic illness. SAMHSA has collaborated closely with NIMH in providing guidance and technical assistance to States regarding effective programs funded by this set-aside. SAMHSA and NIMH are also working with the Office of the Assistant Secretary for Planning and Evaluation (ASPE) within HHS on an initial examination of how States are utilizing the set-aside funding.

Certified Community Behavioral Health Clinics

SAMHSA has also been working closely with Centers for Medicare & Medicaid Services (CMS) and ASPE to improve the quality and coordination of care for adults with serious mental illness, children with serious emotional disturbance, and those with long-term and serious substance use disorders, through implementation of the demonstration program for Certified Community Behavioral Health Clinics established by the Protecting Access to Medicare Act (also known as section 223). Last week, SAMHSA awarded planning grants to 24 States to certify community behavioral health clinics, establish a prospective payment system to reimburse clinics for services to Medicaid recipients, and to prepare to participate in a 2-year demonstration program. States will certify agencies meet certain criteria developed by SAMHSA, such as staffing requirements, standards for availability and accessibility of services, including prompt evaluation and crisis management services, and that provide a comprehensive scope of services including extensive requirements for enhanced care coordination. In addition, community behavioral health clinics will be required to report on quality measures that will include care coordination. An evaluation of the demonstration program will be conducted by ASPE in close collaboration with SAMHSA and CMS.

Transforming Lives through Supported Employment

For people with serious mental illness, employment contributes to stability and independence. Unfortunately, many of these individuals are unemployed. In fiscal year 2014, SAMHSA initiated a new $5.6 million program, Transforming Lives through Supported Employment, to promote the employment of people with serious mental illness, and this initiative includes collaboration with the Department of Education, the Department of Labor, and States, among others. Transforming Lives through Supported Employment grants help people with serious mental illnesses discover paths of self-sufficiency and recovery rather than disability and dependence. These grants support States that establish a supported-employment program in two communities within the State, secure sustainable funding for on-going community supportive employment services, establish a permanent training program using in-person and virtual platforms, and collect and analyze program data. The goal of the program is to increase the number of individuals with serious mental health obtain gainful employment.

Suicide Prevention

Suicide is a serious public health crisis—approximately 41,000 Americans die by suicide each year.[4]

SAMHSA has many initiatives that help prevent suicide and suicide attempts. For example, the National Suicide Prevention Lifeline (1-800-273-TALK), which works with the Department of Veterans' Affairs, has helped more than six million people since its inception in January 2005. SAMHSA also received funding for the first time in fiscal year 2014 for Tribal Behavioral Health Grants that aim to reduce suicide and substance misuse and abuse among American Indian/Alaska Native youth.

The Garrett Lee Smith Memorial Act State and Tribal grant program is SAMHSA's largest suicide prevention program and is focused on reducing suicide and suicide attempts among youth and young adults 10 to 24 years old. Evaluation of the impact of these grants has shown that counties that have implemented grant-supported suicide prevention activities have lower rates of youth suicide and non-

[4] American Association of Suicidology. (2015). *USA Suicide 2013 Official Final Data.*

fatal suicide attempts than matched counties without such activities in the year following the suicide prevention activities.

At the same time, SAMHSA's suicide prevention grant programs, as currently funded, almost exclusively focus on reducing suicide among youth and adolescents. However, data shows that in 2013, the latest year for which suicide completion data is available, 87 percent of individuals who died by suicide were over age 24.[5] As the country moves forward in addressing this public health crisis, more attention must be paid to addressing suicide among adults. One particular promising model for doing so is Zero Suicide, an initiative to eliminate suicides among individuals under care within health and behavioral health systems. This initiative has seen promising results such as at Centerstone, a non-profit community-based behavioral-health-care provider based in Tennessee.

IMPROVING THE BEHAVIORAL HEALTH SYSTEM

Workforce

The Affordable Care Act builds on the Mental Health Parity and Addiction Equity Act of 2008 to extend Federal parity protections to 62 million Americans.[6] The current behavioral healthcare infrastructure and workforce, however, will need additional capacity to absorb the influx of patients with behavioral health needs who now have the coverage to seek treatment. Research has identified the need for additional prescribing and non-prescribing behavioral health professionals, including psychiatrists, social workers, counselors, and therapists.[7]

The President's fiscal year 2016 Budget includes $77.7 million for SAMHSA for behavioral health workforce programs. This includes $10.0 million for a new program entitled Peer Professional Workforce Development. These grants would provide tuition support and further the capacity of community colleges to develop and sustain behavioral health paraprofessional training and education programs. Overall, this new program would result in adding approximately 1,200 peer professionals to the current behavioral health workforce. The Budget also includes $56 million for the SAMHSA–HRSA Behavioral Health Workforce Education and Training (BHWET) Grant Program to expand the behavioral health workforce.

This additional funding would add approximately 5,600 health professionals to the workforce. SAMHSA's collective workforce efforts will help add several thousand new professionals to the workforce each year. In addition, SAMHSA, HRSA, and CMS engaging in ongoing work to promote integration of behavioral health and primary care services which will also help improve access to care.

Crisis Systems

In addition to building the behavioral health workforce, there is also a pressing need for more accessible and appropriate community crisis systems. In 2010, 2.2 million hospitalizations and 5.3 million emergency department visits involved a diagnosis related to a mental illness.[8]

Such services as 24-hour crisis stabilization, warm lines that provide peer support for people living with mental illness to help prevent a crisis, peer crisis services, mobile crisis services, short-term crisis residential services, and community-based crisis followup services can help avoid unnecessary and expensive hospitalization and emergency department visits and provide improved outcomes for adults and children with behavioral health conditions. However, many communities encounter challenges in funding and coordinating these systems.

People with serious mental illnesses and their families often find themselves facing crisis situations in which the only available care is overworked emergency departments often ill-equipped to address the needs of such individuals. That is why the President's fiscal year 2016 Budget includes $10 million in new funding for a demonstration program designed to help States and communities test the best way to structure, fund, and deliver services to prevent, de-escalate, and followup after behavioral health-related crises to assure the individual, family, community, and delivery systems are adequately supported. These grants can help in coordinating effective crisis response with ongoing outpatient services and supports.

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[5] CDC's WISQARS website "Fatal Injury Reports," *http://www.cdc.gov/wisqars/index.html*.

[6] *http://aspe.hhs.gov/health/reports/2013/mental/rb_mental.cfm*.

[7] KC Thomas, et al. County-Level Estimates of Mental Health Professional Shortage in the United States, Psychiatric Services, 60:1323–28, 2009.

[8] Agency for Healthcare Research and Quality. (2010). *Healthcare Cost and Utilization Project (HCUP). Custom data query.* Retrieved from *http://www.hcup-us.ahrq.gov/*.

CONCLUSION

SAMHSA has made important strides in the prevention, treatment, and recovery supports for mental and substance use disorders. However, we know that more work remains. We look forward to continuing to work with the Congress on these efforts. I would be pleased to answer any questions that you may have.

The CHAIRMAN. Thank you, Ms. Enomoto.

Mr. Macrae.

STATEMENT OF JIM MACRAE, M.A., M.P.P., ACTING ADMINISTRATOR, HEALTH RESOURCES AND SERVICES ADMINISTRATION, ROCKVILLE, MD

Mr. MACRAE. Thank you, Chairman. Thank you, Chairman Alexander, Ranking Member Murray, and all members of the committee.

I am pleased to join my colleagues today to share with you what we are doing at the Health Resources and Services Administration to address the mental health needs in our Nation.

As my written testimony conveys, HRSA is the primary Federal agency within the Department of Health and Human Services charged with improving access to health care services for people who are medically underserved, including those who are low-income, live in rural communities, and vulnerable populations.

We carry out our work in partnership with community-based organizations, State and local governments, and academic institutions, among others.

HRSA's programs and its over 3,000 grantees provide affordable health care to tens of millions of Americans across the country, and we train thousands of health care professionals.

One key area of our work has been on expanding behavioral health within primary care settings, as Ranking Member Murray mentioned. HRSA recognizes that primary care can often serve as a critical access point for those suffering from mental health issues, as some individuals often feel less stigma and feel more comfortable discussing and sharing their mental health concerns with their primary care providers.

For example, in our Community Health Center program, depression and anxiety are ranked third and fifth as the most important reasons why people come to the health center, to a primary care setting. Health centers have also shared with us that by having a mental health provider actually on staff and co-located in that primary care setting, that their other primary care providers actually feel more comfortable and are better able to address the mental health care needs of their patients and better able to coordinate their care.

To support this type of integration that we have heard from our health centers that they need, HRSA has invested more than 160 million in the past year to expand the mental health capacity at health centers nationwide. We have done this through either establishing new mental health services or expanding existing services. Through those investments, we hope to provide care to an additional 1 million people suffering from mental illness.

In addition, HRSA, with SAMHSA, jointly supports the Center for Integrated Health Solutions. This is a national technical assistance resource that helps health centers and other HRSA safety-net

providers on the mechanics of actually integrating primary care and mental health and substance abuse services, how best to actually do it.

One of the other keys, though, to addressing access to mental health care services is of course building a strong mental health workforce so that individuals can see a provider when they need one. The National Service Corps, which is one of our key programs, provides scholarships and repays the loans for those who are practicing in underserved communities either in primary care, dental, or behavioral health. In return, they agree to provide service for 2 to 4 years in designated areas of the country that need them most.

In particular, the National Health Service Corps places a number of mental health and behavioral health providers, including psychiatrists at facilities in high-need mental health profession shortage areas. Since 2008, the number of mental health providers in the National Health Service Corps has increased from about 800 to well over 3,300 in 2015.

In addition, our agency also supports a number of health workforce training programs that help increase the mental health training of our providers nationwide. For example, since 2014, in collaboration with SAMHSA, HRSA has administered the Behavioral Health Workforce Education and Training grant program as part of the Administration's *Now Is the Time* initiative. These grants have enabled more than 1,100 master's-level social workers, psychologists, and marriage and family therapists, as well as more than 950 mental health paraprofessionals to receive clinical training in academic years 2014 and 2015.

We also, though, recognize that mental health is in particular a need in our rural communities. In particular, despite the need per capita, there are fewer mental health providers in rural communities compared to urban ones, and through the use of telehealth, telemedicine, as well as health information technology, HRSA has expanded support for providers in rural and isolated areas of the country to improve patient care.

Last, we also recognize that mental health and substance use disorders are also common in persons living with HIV and AIDS and are critical barriers to both retention in care, as well as adherence to treatment. Through our Ryan White programs, we support training for our providers to screen, identify, and treat those with substance abuse or mental health needs.

In conclusion, HRSA shares the goal of ensuring a strong primary care health system that supports quality mental health and substance abuse services in particular by integrating an expanded capacity of behavioral health into primary care, training more behavioral health providers, and utilizing new methods and technologies such as telemental health to reach underserved populations.

We look forward to continuing our work with your committee, as well as others in Congress, to address the Nation's mental health and substance abuse needs.

Thank you.

[The prepared statement of Mr. Macrae follows:]

PREPARED STATEMENT OF JAMES MACRAE, M.A., M.P.P.

Good morning Chairman Alexander, Ranking Member Murray, and members of the committee. I am Jim Macrae, Acting Administrator at the Health Resources and Services Administration (HRSA). I appreciate the opportunity to join my colleagues today and share with you some of the activities underway at HRSA to address the mental health needs of our Nation. In appearing before you, I bring the perspective from my vantage point as the Acting Administrator at HRSA as well as the former head of HRSA's Bureau of Primary Health Care. In both of these capacities, I have had the privilege of leading important primary health care activities to improve the health of individuals and families throughout the United States.

HRSA is the primary Federal agency within the Department of Health and Human Services (HHS) and across the Federal Government charged with improving access to health care services for people who are medically underserved because of their economic circumstances, geographic isolation, or serious chronic disease, among other factors. To address these issues, HRSA works through partnerships with States, community-based organizations, academic institutions, health care providers, and others to improve our primary care infrastructure, strengthen the health care workforce, and achieve health equity. HRSA works closely with the Substance Abuse and Mental Health Services Administration (SAMHSA), the National Institutes of Health and other HHS divisions through the Department's Behavioral Health Coordinating Council (BHCC) and other mechanisms to collaborate on initiatives related to mental health.

This committee has a long history of leadership on and engagement in a number of HRSA programs and activities including the Community Health Centers, the National Health Service Corps, the Federal Office of Rural Health Policy, and the Ryan White HIV/AIDS Program. To begin, I want to thank members of this committee and your colleagues in the Senate and the House of Representatives for the bipartisan, bicameral efforts that you undertook earlier this year in passing the Medicare Access and CHIP Reauthorization Act of 2015. That legislation extended funding for, among other things, the Health Center Program and National Health Service Corps. The President's Budget for these and other HRSA programs also provide important health resources focused on primary health care, including the integration of mental health services.

Since 2008, HRSA's efforts to increase access to mental health services have included the following:

- With the support of the Affordable Care Act and other investments, health centers have added more than 3,000 mental health providers to expand access to mental health services in primary care settings. As a result of these efforts, today, health centers employ nearly 6,400 mental health providers.
- With the support of the Affordable Care Act and other investments, the number of mental health providers in the National Health Service Corps (who receive scholarships and loan repayment for practicing in underserved areas) has quadrupled, increasing from approximately 800 in 2008 to more than 3,300 in 2015.
- In response to the President and Vice President's *Now is the Time Initiative*, since fiscal year 2014, HRSA has worked with SAMHSA to help expand the mental health workforce by supporting clinical training of approximately 1,156 additional masters level social workers, psychologists and marriage and family therapists and 960 mental health paraprofessionals.

SUPPORTING PRIMARY CARE MENTAL HEALTH INTEGRATION

Across HRSA, there are a range of programs and resources that support primary and mental health care integration.

Health Center Program

One particular area of focus of our primary and mental health care integration has been within our Health Center Program. Health centers provide an accessible, affordable, and dependable source of primary care for uninsured and medically underserved patients. HRSA supports nearly 1,300 health centers operating approximately 9,000 health center service sites across the country, and approximately 50 percent of them serve rural communities. Today, 1 in 14 people receive care at a HRSA-supported health center, including 1 in 7 people living at or below the Federal poverty level. For the 23 million patients served annually, health centers provide comprehensive, high-quality, cost-effective primary health care regardless of patients' ability to pay.

Increasingly, as recognized providers of primary health care services, health centers are also experiencing a greater demand for mental health services. Some health center patients have shared with their providers that they often feel more com-

fortable discussing and sharing their mental health concerns within a primary care setting rather than a traditional mental health facility. For example, in 2014, according to health center program data, depression and anxiety disorders, including post-traumatic stress disorder (PTSD), ranked third and fifth, respectively, among the top 10 reasons that a patient visited a health center. In 2014, we invested $166 million in Affordable Care Act funding to expand mental health capacity at health centers, which is expected to establish or expand services to more than one million people nationwide. As a result, even though the statute does not require health centers to have a mental health specialist on staff to be eligible for health-center funding, health centers increasingly have opted to integrate mental health providers into their primary care operations, or have built strong relationships with other community mental health providers. In addition, health centers have shared with us that by having a mental health provider on staff and co-located in the primary care setting, their other primary care providers are better able to address the mental health needs of their patients and coordinate their care.

Integrating mental health care into primary care presents a unique opportunity for patients and providers. Approximately 84 percent of health centers nationwide currently provide mental health treatment and counseling onsite or under contracts with other providers, resulting in more than 6.2 million mental health visits in 2014.

In addition, HRSA and SAMHSA jointly support the Center for Integrated Health Solutions (CIHS), which offers direct technical assistance and a wide-range of resources to health centers and other HRSA-funded safety-net providers regarding integrating mental health and substance use services within primary care settings. For example, CIHS has developed a rural-specific, interactive, 8-hour training course that presents an overview of mental illnesses and substance use disorders in the United States. The course introduces participants to risk factors and warning signs of mental health or addiction problems, builds understanding of their impact, and reviews treatments.

BUILDING A STRONG MENTAL HEALTH WORKFORCE

While the Health Center Program focuses on delivering patient care, HRSA's health workforce programs target the education, training, and distribution of a highly skilled primary care workforce through health professions training, curriculum development, and scholarship and loan repayment programs. HRSA's efforts support a diverse and culturally competent primary care workforce that delivers high quality, efficient health care. A key program focus at HRSA is to increase access for Americans to a mental health care provider through its health professional training programs.

HRSA supports several grant programs that work to expand access to mental health services by increasing the number of mental health providers. HRSA has made important investments with workforce program funding supporting the training of mental health disciplines, including physicians, nurses, and physician assistants with psychiatric specialties.

HRSA's National Health Service Corps (NHSC) programs provide scholarships and repay educational loans for primary care, dental, and mental and behavioral health clinicians who agree to 2, 3 or 4 years of service in designated areas of the country that need them most. Overall, NHSC clinicians provide preventive and primary care to approximately 9.7 million people.

Over one in three NHSC clinicians—3,371 out of 9,683—provided mental and behavioral health services. This includes psychiatrists, psychiatric physician assistants, psychiatric nurse practitioners, health service psychologists, licensed clinical social workers, licensed professional counselors, marriage and family therapists, and psychiatric nurse specialists. Of these 3,371 mental health providers in the NHSC field, 1,231 (37 percent) are in rural communities, and 116 (3 percent) are practicing in Indian Health Service facilities.

In addition to NHSC programs, HRSA supports a wide range of other workforce training programs to increase the number of mental health providers. The Mental and Behavioral Health Education and Training Programs support increased access to services by training providers. Between academic year 2012–13 and 2014–15, the number of students supported by stipends increased from 86 to 214. The Scholarships for Disadvantaged Students (SDS) program increases diversity in the health workforce by providing grants to eligible health professions schools to award scholarships to students from disadvantaged backgrounds, including those pursuing degrees in mental health. In academic year 2014–15, there were 411 students pursuing mental health disciplines who received SDS scholarships The Geriatrics Workforce Enhancement Program also supports various mental health disciplines, includ-

ing psychiatrists, psychologists, social workers, psychiatric nurses, professional counselors, marriage and family therapists and substance abuse counselors.

Additionally, since fiscal year 2014, HRSA has worked with SAMHSA to administer the Behavioral Health Workforce Education and Training grant program (BHWET) as part of the Administration's *Now is the Time Initiative*. As I noted in my testimony earlier, these grants help expand the mental health workforce by supporting clinical training of approximately 1,156 additional masters level social workers, psychologists and marriage and family therapists and 960 mental health paraprofessionals in academic year 2014–15. Through this initiative, HRSA and SAMHSA have partnered to address critical needs for mental health professionals and paraprofessionals trained to address the needs of transition-age youth (ages 16–25). The President's fiscal year 2016 Budget proposes $56 million for the BHWET program, an increase of $21 million over fiscal year 2015.

STRENGTHENING MENTAL HEALTH ACTIVITIES IN RURAL AREAS

Per capita, there are fewer mental health providers (ranging from counselors to psychologists) in rural as compared to urban communities. To support access to mental health services in rural communities and to better reach populations in rural settings, HRSA has expanded support for providers in rural and isolated areas to improve patient care through the use of telehealth, telemedicine and health information technology. These emerging health tools utilize electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health, and health administration.

HRSA's Telehealth Network Grant Program supports efforts to demonstrate how telehealth technologies can be used through telehealth networks to increase the number of communities that have access to pediatric, adolescent, and adult mental health services. As a result of $5.4 million in funding from this program in fiscal year 2015, more than 300 communities now have access to telehealth services. In addition, the Flex Rural Veterans Health Access Program provides grants to States to support telehealth and health information exchange projects to enhance care for veterans in rural areas.

HRSA also funds a number of community-based grant programs designed to improve access to and coordination of care in rural communities, with roughly one quarter of the fiscal year 2015 projects focusing on mental health care.

MEETING MENTAL HEALTH NEEDS IN OTHER HRSA INITIATIVES

The Ryan White HIV/AIDS Program (RWHAP) is an example of where we see contributions to addressing the mental-health needs of the Nation in other programs as well.

Mental illness occurs in persons living with HIV/AIDS at almost twice the rate as in the general population. Mental health and substance-use disorders are common in persons living with HIV/AIDS and are critical barriers to retention in care and adherence to treatment. In fact, for the RWHAP, mental health represents the third-highest category of visits and approximately 14 percent of clients received mental health services. In Parts A and B, where we have available expenditure data, approximately $32 million was spent on mental health services in fiscal year 2013. Of those who received mental-health services, 78 percent were virally suppressed and 88 percent were retained in care; overall, 79 percent of clients served by the RWHAP are virally suppressed and 81 percent are retained in care.

CONCLUSION

Mr. Chairman, we share the goal of ensuring a strong Federal primary health care system that supports quality mental health care. As I have outlined today, with our multifaceted strategy, we are employing many effective tools to maximize our reach and provide quality and accessible mental health services and mental health care professionals. HRSA will continue to seek ways to enhance these services and related resources in partnership with our colleagues across the Department and with communities across the country. I appreciate the opportunity to testify today.

The CHAIRMAN. Thank you, Mr. Macrae.

Dr. Insel.

STATEMENT OF THOMAS INSEL, M.D., DIRECTOR, NATIONAL INSTITUTE OF MENTAL HEALTH, BETHESDA, MD

Dr. INSEL. Thank you, first, for holding this hearing. It is really, for me, important to see the priority that both of you have put on this issue and how several members of the committee have expressed their passion. Some of this I know, Senator Murray, as you said, comes from every one of us having a personal experience, so this is something that we care about.

Mr. Chairman, you nicely laid out that this is very much a partnership between Federal, State, and private sector, and how we do that going forward has got to be better than what we have done up until now.

I am not going to read my testimony. You have that. I want to simply add to the comments from my colleagues here that there is a lot going on that is worth talking about. Senator Murray, as you kind of clicked through your list of the issues around the workforce, the opportunity of collaborative care, what we are doing for crisis response, certainly suicide and the stigma, as you have heard, we are already, as a partnership here across these agencies, very engaged on those issues.

It is incredibly important to have HRSA here because we have to always remember that the brain is part of the body, and that mental health issues need to be thought of as health issues. Many people with serious mental illness also have issues around diabetes and metabolic syndrome and tremendous number of problems with the fact that about two-thirds of them are smokers and so they develop chronic pulmonary disease. One of the reasons why people with a serious mental illness die 10 years early, as you mentioned, is not because of suicide so much as of all the chronic and often very expensive medical complications that they develop for a variety of reasons.

These are huge health issues that need all of our attention, and we need to be thinking about how to address them in the most impactful way.

As you have all mentioned and understand, we at NIMH, as part of NIH, we are the research part of this. We do the science and the science is changing as well, partly because of the BRAIN initiative, partly because of our understanding that we can now address mental disorders as brain disorders. We have the tools to be able to change the way we do diagnosis to be able to develop new kinds of treatments. Most of all, the understanding that we have here very much coming out of our experience with heart disease and cancer, that if we are going to bend the curve, we have to detect early, intervene early. We have to really move upstream.

So much of our past focus in this area has been on people with chronic disability. That is obviously very important for us to do. The future has to be much better detection and much earlier intervention, and then developing, as Kana mentioned, these comprehensive treatments for early psychosis to ensure that someone who does actually develop psychosis, if we fail to preempt it, gets the best chance for recovery.

The focus on reducing suicide, as you mentioned, Senator Murray—this is just an area that has not budged. In the same time when homicide has come down 50 percent, we are still looking at

about the same suicide rate we had in 1990. We have got to understand how to address that in a better way.

My last comment, as many of you have noted, this is my swan song, and I am in some ways wistful about leaving the position. I am leaving a lot of people I care about so much and certainly want to continue to focus on these issues now from the private sector.

I did want to share with you what I mentioned in my testimony, which is—in leaving, as I look back on what have I learned—what are the sort of abiding truths that I would carry with me and want to convey, there are really two factors that come back to me over and over again.

One is that we can do much, much better than we are doing currently with the diagnostics and the treatments we have. There is just in this field, more than in many areas of medicine, just this unconscionable gap between what we know and what we do. Both of you spoke to that a little bit in your opening statements. We are all aware of that from our own communities or from our own personal experience. This is a huge gap that we have got to figure out how to bridge.

At the same time I want to stress that, as with heart disease and cancer and maybe even more so in this area, we do not know enough. We just do not know enough to ensure that everyone will recover, to have a cure for every one of the problems that people with schizophrenia, depression, bipolar disorder, or autism develop. These are really difficult, complicated problems, and we have got to invest not only in better services but also in more science. It is going to be essential that we understand these disorders at a deeper level if we are going to come up with the treatments that are going to be most effective.

I think we can do it. In my career I have seen this happen for childhood cancer. I have seen it happen for heart disease where the mortality has come down 63 percent. I have seen it happen recently for AIDS with the mortality coming down 50 percent. We have not seen those numbers budge for morbidity and mortality in this area, and that is something we have got to tackle in a new way, fresh ideas, better science, and closing this gap to take the things we know today and make sure that is what we are actually doing in practice.

Thank you very much. I look forward to your questions.

[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 (HHS). Thank you for this opportunity to provide an update on the 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 disseminate new treatments for these brain disorders. 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

NIMH is the lead Federal agency for research on mental health, 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 10 million American adults (approximately 4.1 percent of all adults)

suffer from a serious mental illness (SMI) each year,[1] including conditions such as schizophrenia, bipolar disorder, and major depression. According to a recent Global Burden of Disease study, neuropsychiatric disorders are the leading cause of disability in the United States in 2010, accounting for 18.7 percent of all years of life lost to illness, disability, or premature death (Disability-adjusted Life Years, or DALYs).[2] The personal, social, and economic costs associated with these disorders are tremendous. Suicide is the second leading cause of death among American youth and young adults aged 15–34, and accounts for the loss of more than 41,000 American lives across all age groups each year, more than triple the number of lives lost to homicide and more than the deaths from breast cancer.[3] [4] 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.[5] [6] Even more concerning, the burden of illness for mental illnesses is projected to sharply increase, not decrease, over the next 20 years.[7]

NIMH-supported research has found that Americans with SMI die up to 10 years earlier than the general population.[8] The low rates of prevention, detection, and intervention for chronic medical conditions and their risk factors among people with SMI contribute to significant illness and earlier death. Two-thirds or more of adults with SMI smoke;[9] over 40 percent are obese (60 percent for women);[10] [11] and metabolic syndrome is highly prevalent, especially in women.[12] In addition, people with SMI frequently have co-occurring substance use disorders, and practitioners are often called upon to address mental illness and substance use problems simultaneously. Approximately 5 percent of individuals with schizophrenia will die by suicide during their lifetime, a rate 50-fold greater than the general population.[13]

DELAYS IN RECEIVING TREATMENT—AND THE CONSEQUENCES

While most people with SMI eventually make contact with a health care professional, delays in seeking care can be extensive.[14] In a recent NIMH-funded study of first episode psychosis (FEP) in 22 States, the average duration of untreated psychosis was approximately 74 weeks—six times the World Health Organization's (WHO's) standard for initiating early psychosis services (*i.e.*, 12 weeks). The period

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[1] Substance Abuse and Mental Health Services Administration. *Results from the 2014 National Survey on Drug Use and Health: Mental Health Detailed Tables: http://www.samhsa.gov/data/sites/default/files/NSDUH-MHDetTabs2014/NSDUH-MHDetTabs2014.htm* (accessed October 2015).

[2] US Burden of Disease Collaborators. The state of US health, 1990–2010: burden of diseases, injuries, and risk factors. *JAMA,* 310(6): 591–608, 2013.

[3] Centers for Disease Control and Prevention (CDC), National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS): *www.cdc.gov/ncipc/wisqars* (accessed October 2015).

[4] CDC, National Violent Death Reporting System, 2012. WISQARS: *www.cdc.gov/ncipc/wisqars* (accessed October 2015).

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

[6] 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.

[7] 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.

[8] Walker ER, McGee RE, & Druss BG. (2015). Mortality in mental disorders and global disease burden implications: a systematic review and meta-analysis. *JAMA Psychiatry*, 72(4), 334–41.

[9] 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.

[10] 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.

[11] McElroy SL. Correlates of overweight and obesity in 644 patients with bipolar disorder. *J Clin Psych.* 2002;63:207–13.

[12] 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.

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

[14] 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.

immediately after the onset of psychosis when young people lose touch with reality and experience hallucinations and delusions is a critical timeframe for intervention.

HOW NIMH IS ADDRESSING THIS PUBLIC HEALTH CHALLENGE

In the past, we viewed mental illnesses as behavioral conditions defined by their symptoms. Increasingly, research reveals that mental illnesses are brain disorders, with specific symptoms rooted in abnormal patterns of brain activity. In brain disorders, as a general rule, symptoms represent a late stage of a process that began years earlier. To achieve the greatest impact, our interventions should be focused on earlier, pre-symptomatic phases of illness, with a goal of preempting the disability of a chronic behavioral syndrome. Moving forward, NIMH aims to support research on earlier detection and earlier treatment. NIMH has a three-pronged research approach to achieve this aim: (1) optimize treatment to improve the trajectory of illness in people who are already experiencing the symptoms of SMI; (2) preempt the transition from the pre-syndromal (prodromal) phase to the acute phase of illness; and (3) define the risk architecture of SMI in order to move from preemption to prevention. As examples of the approach, here are four NIMH efforts on these fronts in psychosis:

(1) NIMH is continuing to support the Recovery After an Initial Schizophrenia Episode (RAISE) initiative, 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. RAISE began with two studies examining different aspects of coordinated specialty care (CSC) treatments for people who are experiencing FEP in a range of clinics, so that the results are relevant to community treatment settings throughout the country. RAISE investigators have recently shown that CSC for FEP improves psychopathology, work and school functioning, and quality of life compared to usual community care. Importantly, improvements are greatest among individuals with a shorter duration of untreated psychosis, suggesting that both the timing and content of treatment are critical.[15] Moreover, in 2014, the Congress allocated a 5-percent set-aside to the Substance Abuse and Mental Health Services Administration (SAMHSA) for the Mental Health Block Grant program to develop early psychosis treatment programs, and further directed SAMHSA to collaborate with NIMH in developing input for States regarding evidence-based FEP treatment models such as CSC. An initial evaluation of the set-aside program has shown increased access to services. An upcoming, more comprehensive evaluation will measure key symptomatic and functional outcomes from the set-aside evaluation. Building on the lessons learned from studying CSC, NIMH plans to link a series of clinics to launch the Early Psychosis Intervention Network (EPINET), an effort that will create a learning health care system within early psychosis treatment settings, in order to improve the effectiveness of early psychosis treatment.

(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 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. NAPLS investigators recently reported that clinical factors such as disorganized communication, suspiciousness, compromised verbal memory, and declining social function indicate an increased risk for conversion to psychosis among adolescents.[16]

(3) NIMH's initiative, *Research to Improve the Care of Persons at Clinical High Risk for Psychotic Disorders*,[17] has funded seven clinical trials to expand knowledge regarding effective interventions during the prodromal phase, to build an evidence base to support high-quality community care focused on preempting psychosis and improving long-term outcomes.

(4) The NIMH-funded Psychiatric Genomics Consortium (PGC), the largest ever genomic dragnet of any psychiatric disorder—involving over 200,000 samples from 80 institutions across 25 countries—has identified overlapping genetic risk among schizophrenia, bipolar disorder, and depression for pathways affecting the immune

[15] Addington J, et al., Duration of untreated psychosis in community treatment settings in the United States. *Psych Serv.* 2015 October (in press).

[16] Cornblatt BA, Carrión RE, Auther A, McLaughlin D, Olsen RH, John M, Corell CU. Psychosis prevention: a modified clinical high-risk perspective from the recognition and prevention (RAP) program. *Am J Psychiatry.* 2015 Oct;172(10):986–94.

[17] *http://grants.nih.gov/grants/guide/rfa-files/RFA-MH–14–211.html.*

system and brain cell communication.[18] These findings may help lead the way toward the development of treatments for such SMIs.

In addition to these and other similar efforts, NIMH collaborates with other HHS agencies and other public and private partners to evaluate and promote SMI programs and to improve access to early intervention treatment for psychosis. For example, together with SAMHSA, NIMH co-chairs the HHS Behavioral Health Coordinating Council's Subcommittee on SMI. The subcommittee is charged with coordinating research, treatment, and supports for Americans with SMI, through collaborative, action-oriented approaches across HHS, and by contributing to the development of the Secretary's action plan to address the needs of Americans living with SMI. Another important example of trans-HHS—and, in fact, trans-Departmental—collaboration is the Brain Research through Advancing Innovative Neurotechnologies (BRAIN) Initiative.[19] NIMH and the National Institute of Neurological Disorders and Stroke (NINDS) are co-leading the BRAIN Initiative, with participation from 10 NIH Institutes and Centers, the Defense Advanced Research Projects Agency (DARPA), the National Science Foundation (NSF), the U.S. Food and Drug Administration (FDA), and the Intelligence Advanced Research Projects Activity (IARPA). The BRAIN Initiative is accelerating the development and application of innovative technologies to the creation of new tools for decoding the language of the brain.

In addition to our work on psychosis, NIMH also supports a range of mental health research on autism spectrum disorder, attention deficit-hyperactivity disorder, eating disorders, mood disorders, and post-traumatic stress disorder (PTSD). NIMH is partnering with other NIH Institutes and other Federal agencies as part of the National Research Action Plan to develop biomarkers, define the pathophysiology, and create new treatments for PTSD. NIMH-funded researchers recently reported that a computerized attention-control training program significantly reduced combat veterans' preoccupation with—or avoidance of—threat and attendant PTSD symptoms.[20]

Moreover, NIMH has played a key role in developing a prioritized research agenda for suicide prevention.[21] The Institute funded a series of ongoing grants that address the six key questions that organize the research agenda, and developed a $12 million initiative to solicit research to improve screening and risk stratification for suicidal youth who present for care in emergency departments. NIMH has also recently announced a partnership with the NIH Office of Behavioral and Social Sciences Research and the National Institute of Justice to support the Suicide Prevention for at-Risk Individuals in Transition (SPIRIT) study.[22] This study will evaluate the effectiveness of an evidence-based Safety Planning Intervention for reducing suicide events in the year following incarceration among persons recently released from jail. NIMH is working with SAMHSA and other Federal partners, including the Departments of Veterans Affairs and Defense, to address the issue of suicide among middle-aged adults, a demographic at high risk for suicide.

PREEMPTION: THE FUTURE OF MENTAL HEALTH RESEARCH

Research has taught us to detect diseases early and to 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.[23] The 100,000 young Americans who will experience FEP this year will join over two million with schizophrenia.[24] Our best hope of reducing mor-

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[18] The Network and Pathway Analysis Subgroup of the PGC. Psychiatric genome-wide association study analyses implicate neuronal, immune and histone pathways. *Nat Neurosci.* 2015 Feb;18(2):199–209.

[19] *http://www.nih.gov/science/brain/index.htm*.

[20] Badura-Brack AS, Naim R, Ryan TJ, Levy O, Abend R, Khanna MM, McDermott TJ, Pine WSD, Bar-Haim Y. Effect of attention training on attention bias variability and PTSD symptoms: randomized controlled trials in Israeli and US combat veterans. *Am J Psychiatry,* 2015 July.

[21] *http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/Agenda.pdf*.

[22] See: *http://www.nimh.nih.gov/news/science-news/2015/embracing-the-spirit-of-reducing-suicide.shtml*.

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

[24] Calculated from McGrath J., Saha S., Chant D., & Welham J. Schizophrenia: a concise overview of incidence, prevalence, and mortality. *Epidem Rev,* 2008; 30, 67–76.

tality from schizophrenia, other SMIs, 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. This is our call to action.

Mr. Chairman, as you know, this is my final hearing in front of your committee as the Director of NIMH. After 13 years of public service at NIMH, I have lost count of the number of times I have testified in front of this committee. It has been an honor to serve at NIMH and to work with members of this committee. I leave with great pride in what we have accomplished and with great anticipation for the potential of research to improve the lives of people with mental illnesses. My tenure at NIMH has convinced me of two abiding truths about the state of mental health care in our Nation. First, we can do much better delivering the treatments we have today. Second, today's treatments are not good enough. Too many people are untreated, and too many who are treated get better, but do not get well. Going forward, I hope the committee understands that families challenged by mental illness need both the immediate benefit of high-quality services, as well as a future of better services from high-quality science.

The CHAIRMAN. Thank you, Dr. Insel.

We will now have a round of 5-minute questions.

Dr. Insel, did you say that two-thirds of those with mental health were smokers?

Dr. INSEL. With serious mental illness——

The CHAIRMAN. With serious——

Dr. INSEL [continuing]. Particularly with schizophrenia. The numbers even climb higher than two-thirds.

The CHAIRMAN. Is that a lot higher than for people with diseases other than mental health?

Dr. INSEL. Yes, absolutely. It is not higher than when you look at males with lung cancer. They have very high rates of smoking as well. As a group, I do not think there is any medical demographic group that high rate of smoking that you see in people with serious mental illness.

And I might add that it is not just that they are smokers but the way in which people with chronic schizophrenia smoke is actually quite different than the way other people smoke. They consume more cigarettes, they inhale further, and they are much, much more likely to develop chronic respiratory disease as a result. It is a huge comorbidity, a huge medical public health problem.

We have launched, and SAMHSA has worked with us on many of these efforts, these new programs to get people with schizophrenia who are chronically ill to stop smoking. It is doable but it is a tough slog. It is hard for them to stop, and there have always been questions about whether nicotine in some ways is a way of self-medicating. We are not really quite—the science there is not quite baked.

The CHAIRMAN. Dr. Frieden says that smoking still is the No. 1 killer in the United States.

Let us talk about research just a little bit. Last time you were here you talked about findings from your RAISE study, Recovery After an Initial Schizophrenia Episode. You have done some work since then. What have you found out? What have we done to translate those findings into practice?

Dr. INSEL. Right. RAISE, Recovery After Initial Schizophrenia Episode, was a program in 36 sites across 22 States, community sites to try to understand whether we can do better.

With what we know today, so taking a whole range of interventions from medication, family pscyhoeducation, providing what is called resilience training, looking at both ACT teams and supported

housing, supported employment, all of these things that we have known about for years, putting them together in a package and then delivering them, the results for the primary outcomes were just published about 2 weeks ago, and they are very positive. It looks great.

The most disheartening part of that story was that amongst the nearly 400 subjects that were part of this study, the mean duration of untreated psychosis was 74 weeks, which is just stunning. It is hard to believe.

What we are doing now is moving this forward into communities, working very closely with SAMHSA. Kana mentioned the importance of putting this, what is now called coordinated specialty care, into the State system. It is part of this mental health block grant add-on. There are nearly 32 States that have programs based on this.

We are looking to even expand it further through something called the Early Psychosis Intervention Network, which will create a learning health care system that will actually allow us to have a single electronic health system and a coordinated care effort that can incrementally improve as we go.

It is a high priority for the Institute, a high priority for SAMHSA. It is a great story of teamwork across the agencies as well.

The CHAIRMAN. You referred to your BRAIN initiative. What are the most significant findings so far there? Is this part of the overall BRAIN initiative that Dr. Collins has talked to us about at NIH that he hopes to be able to do?

Dr. INSEL. It is. Dr. Collins has—we sometimes joke he has become a born-again neuroscientist. Though he was trained in another area, he has discovered how spectacular neuroscience is today, and that of almost any area in science, this is a place where we have so much traction and so much excitement.

The BRAIN initiative launched by the President in April 2013 has moved forward. We now have funded our second year, about $84 million that we have invested for over 100 projects across the country. What we are——

The CHAIRMAN. Just within your agency or the entire——

Dr. INSEL. The $84 million is NIH alone.

The CHAIRMAN. NIH.

Dr. INSEL. There are 10 institutes within NIH that are engaged in this. Dr. Walter Koroschetz and I lead it, Dr. Koroschetz at the Neurology Institute, myself from NIMH. It is a partnership, though, with DARPA, with FDA, with IARPA, and with NSF as well. There are many different Federal agencies involved, lots of private partners.

The important thing to understand here is it is really——

The CHAIRMAN. Is $84 million the total funding or just the NIH funding?

Dr. INSEL. NIH funding——

The CHAIRMAN. Yes.

Dr. INSEL [continuing]. In 2014. That is what we are up to. The President has asked that that would go to 150, and that both in the House and Senate there is an ambition to go way beyond that as well for next year, for 2016.

This is not about the specific diseases or brain disorders. It is about developing the technologies to be able to understand how the brain works. We are seeing already fantastic tools being developed across the country.

Without wanting to say too much about it at this time, there is a group in Seattle at the Allen brain institute that has really opened up this whole field for all of us in a way that gives us the excitement that over the next few years we will transform the way we study the brain.

The CHAIRMAN. Thank you.

Senator Murray.

Senator MURRAY. I will just followup with that.

In my home State we have the BrainSpan Atlas, Paul Allen's brain institute, which is in downtown Seattle. Tell us what you can about that and some of the other applied research projects. We have got the Mental Health Research Network there as well that are making amazing strides. We have great hopes for them. Talk a little bit about that.

Dr. INSEL. Yes, I could spend all morning bragging about my colleagues in Seattle.

Let me just quickly tell you what those two projects are. BrainSpan was funded through the Recovery Act, so that was a great opportunity with some additional funding for us to build something that did not exist. It essentially was a way of saying could we create a map for the human brain of where and when genes are expressed. It was an atlas, a reference atlas for all of us to use.

When we find a gene that is associated with autism or with schizophrenia, the first question you ask is, well, is that gene even found in the brain? It is expressed there, and if so, when?

The most significant piece of information that has come out of this work by the Allen Institute is that there are enormous differences in both space and time for how the genome gets read out in the brain, in the human brain, and that the developing brain looks almost like a different organ than the adult brain.

To our amazement, even though we think about schizophrenia and autism and bipolar disorder as neurodevelopmental disorders, it was not until we had this atlas that we began to realize that the genes that we are finding, which may not be that significant in the adult brain, are remarkably important in the developing brain. Often, though they do not get expressed together in adulthood, they sit in the very same cell in the same part of the brain at the same time in development. That is fantastic. We would never know that without this reference atlas. It has been transformative.

The Mental Health Research Network—which was developed through Group Health, Greg Simon in Seattle—is a fantastic opportunity, 10 million patients across actually 12 different States with 11 different health care systems to create a single data framework.

All of these people getting mental health care are now using the same electronic health records, and it has given us a platform to move very quickly to ask questions about what is the best followup after a suicide attempt? If someone shows up in the emergency room, we know that 2 percent of those people after an attempt will

be dead in a year from suicide. That represents about one in five suicides are people who have been in an ER within 12 months.

Can we figure out who those people are? With Greg's help and with the MHRN, which is a vast scale, you can begin to look at how to deploy services for those people to make sure that we bring down the suicide rate in that population.

The MHRN has turned out to be for us an ideal platform to ask very practical questions about how to provide better care. Instead of the classic how do we move research into practice, what they are saying is how do we take practice and move that into research and make sure that every patient becomes a partner.

Senator MURRAY. It is really interesting, exciting, and will really open up this field. Thank you for that.

Ms. Enomoto, let me go back to you in the short time I have left. You talked about suicide in America as a public health crisis. When I was chair of the Veterans' Affairs Committee, I was very focused on improving mental health services and suicide prevention for our veterans.

It is not just veterans that are at risk here. We know suicide is the second-leading cause of death among American Indians and Alaska Natives who are between the ages of 10 and 34. CDC reports that lesbian, gay, and bisexual youth are more than twice as likely to die by suicide as their peers.

Going back, based on some of our experience working with veterans, what lessons have we learned about reducing stigma or encouraging individuals to seek out care and peer counseling, those kinds of things?

Ms. ENOMOTO. Through the work of the Veterans Administration, they have developed a systematic process for suicide screening assessment and risk assessment, and we have learned that it is important to specifically screen for suicidality from that work.

We have also learned the importance of connecting, as Tom has mentioned, connecting after a hospital visit, as well as the need to connect people who do express further desire for services with suicide-specific services. It is not enough just to connect them with the general mental health services but services that are going to address the suicidality itself.

We have seen great progress with these "zero suicide" models. We have also seen them deployed outside of a VA system into other community and health hospital systems, into tribal communities, and it is something that SAMHSA is building its suicide initiative around.

Senator MURRAY. Is it fair to say that in the past we have said do not talk about suicide because you might make it happen and rather gone to a "let us talk about it so it is open and we can prevent it" conversation?

Ms. ENOMOTO. Absolutely. That is a very insightful comment.

Senator MURRAY. Thank you.

The CHAIRMAN. Thank you, Senator Murray.

We have 11 Senators who are here in addition to Senator Murray and me. I am going to ask the Senators and the witnesses if we can try to keep each Q&A session to about 5 minutes. We want everybody to have a chance to join the conversation.

I will call on Senators in seniority if they arrived before the gavel, and first arrival after the gavel. The next Senators will be Senator Collins, Franken, Cassidy, and then Murphy.

Senator Collins.

STATEMENT OF SENATOR COLLINS

Senator COLLINS. Thank you, Mr. Chairman.

Ms. Enomoto, one of the issues in our current mental health system is that it is often far too difficult for parents to get help for their adult children who are suffering from serious mental illness. Over the past few months, I have gotten to know Joe Bruce from Caratunk, ME, who has told me of what happened to his family.

I would like to share his story with you and with my colleagues on the committee in the hope that we can work together to come up with some kind of solution as we look to revise our mental health laws.

Joe's son Will was 24 years old at the time of this tragedy. He had schizophrenia, and yet he was discharged from a psychiatric hospital and returned home without the benefits of any medication. He had a history of serious and persistent mental illness, but he had been advised by federally funded advocates that his parents had no right to participate in his treatment or to have access to his medical records.

According to his father and an extensive *Wall Street Journal* piece, eventually his medical records were released, and they showed that the doctors were all opposed to his being discharged but the advocates had coached him in a way that he was able to secure his release. He was convinced that he was fine and that he could refuse medication and not involve his parents in his treatment.

This ended in a terrible tragedy because Will butchered his mother and killed her. He was in a deep psychotic state at the time, and ultimately he was found innocent by reason of insanity, or not responsible for his actions, and he was recommitted to the same mental hospital from which he had been prematurely discharged.

He is now doing well because he is getting the treatment he so desperately needed, but his father put it this way to me: "Ironically and horribly, Will was only able to get the treatment he needed by killing his mother."

NI want to make two important points.

First, I understand that only a tiny number of Americans with serious mental illness engage in unspeakable acts of violence either toward themselves or others.

Second, I understand that these federally funded advocates can do some enormously valuable work in preventing the abuse of patients who are institutionalized.

I cannot help but wonder how many tragedies that we have witnessed in recent years might have been prevented if those suffering from mental illness had had access to treatment and if the parents of these adult children had more of a role in their treatment. How do we address what admittedly is a very difficult challenge?

Ms. ENOMOTO. Thank you for that question, Senator Collins.

I agree that the circumstances of the Bruce case are extremely tragic, and the loss of anyone in such a horrible act of violence is too much. Our thoughts go out to the Bruce family.

In the case of the Protection and Advocacy program, we believe that it is important to have a program that protects the rights of people with serious mental illness. At the same time, we have worked with the Office of Civil Rights, and they have provided guidance to families to understand and to physicians to understand that, under HIPAA, physicians are able to listen to parents, and when it is in the interest of the patient, that they are able to share information with family members.

There is more to be understood about the circumstances of the Bruce case in particular, but I could not agree with you more that our country needs to better understand how to get people with the greatest need connected with the care that would most benefit them, keep them safe, keep their families safe, and ensure the greatest chance of recovery, as we have seen in this particular situation.

Senator COLLINS. Thank you.

The CHAIRMAN. Thank you, Senator Collins.

Senator Franken.

STATEMENT OF SENATOR FRANKEN

Senator FRANKEN. First of all, I thank the Senator from Maine for raising that. That is a very, very important area, and I know that in the Cassidy-Murphy bill we are addressing that.

Thank you, Mr. Chairman, for this important hearing. This is obviously of enormous importance.

There is so much talk about it. I would like to talk about mental health in schools. Ms. Enomoto, I read that you started in dealing with minority mental health and trauma, which I find very interesting. Treating trauma, is very important in terms of learning in school as a matter of fact, something that we all care about here.

I am proud that some of my work got into the new Every Child Achieves Act in terms of mental health in schools. These provisions will support programs in schools to train staff, everybody from the bus driver to the principal to the custodians to the lunch ladies to the teachers to spot when it looks like a kid might have a mental health issue, and then get that adult to talk to a professional in the school, a counselor, maybe a psychologist to see the kid and refer them if they have a mental health—a serious one to get the appropriate services. We have seen that work.

My understanding is that Project AWARE, which is a grant program created by President Obama in 2013 and administered by your agency, supports exactly this type of mental health training for youth-serving adults, and I am proud that a number of these recipients are in Minnesota.

Can you talk about how the collaboration between schools, mental health providers, and other community-based organizations helps students and families and how this program is helping connect young people to the services that they need?

Ms. ENOMOTO. Absolutely, and thank you for the question.

The program such as the one that you have proposed and the one that we have implemented under Project AWARE do connect

schools, communities, and families with shared information about mental health, about mental illnesses, and about substance use disorders, about what they appear like and what you can do about them. They are not meant to replace treatment or care, but they are meant to raise awareness.

As Senator Murray noted, negative attitudes, lack of understanding, these things are what create barriers for people accessing services. First and foremost, we are educating people, we are helping them understand that these are diseases. These are brain diseases that are treatable, preventable, and recoverable, and so people are more willing to talk to people about what they are experiencing, and offer some solutions. Then because people understand it better, it is less frightening, it is more accessible, and we can move to intervene earlier and get people connected to care more quickly.

Senator FRANKEN. Early intervention, early diagnosis, early treatment is something——

Ms. ENOMOTO. Absolutely.

Senator FRANKEN [continuing]. That we as witnesses——

Ms. ENOMOTO. Right.

Senator FRANKEN [continuing]. Know is so important.

I just want to ask you a little bit about your background in minority health and trauma. We know that trauma reduces a child's ability to succeed in school. What can we do in school to build resilience in kids who have experienced these adverse childhood experiences so that they can overcome them? Because I know it changes the brain chemistry to go through this kind of trauma. Trauma could be witnessing violence, seeing chemical abuse, mental illness, child abuse, all of those subjects, extreme poverty.

What can schools do to build resilience in kids to overcome those early adverse experiences?

Ms. ENOMOTO. There are many evidence-based interventions that are school-based that schools can employ. Through our National Child Traumatic Stress Network and the initiative there, there are many, many resources available online and through technical assistance for schools to learn about those programs that can be done in classroom, those programs that can be done in partnership with families, with communities to help children cope with the experiences that they have had, how to learn positive coping and social development skills, and then for teachers as well how to understand how to modulate classroom environments and climates so that we can create a place where all children can learn well and have healthy and productive lives.

Senator FRANKEN. OK. Thank you. I am out of time.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Franken.

Senator Cassidy.

STATEMENT OF SENATOR CASSIDY

Senator CASSIDY. Hello, you all. Thank you for being here.

By the way, let me just thank many in the audience who have sent a letter in support of the bill that Senator Murphy and I have put up.

I thank you all for your concern and for being here.

I am going to ask two questions. I only have 5 minutes, now 4 minutes and 45 seconds, and so please keep your answers brief, and if I interrupt, it is not to be rude or pre-emptory. It is just because I have got limited time.

Ms. Enomoto, GAO has released two reports this year critical of how HHS has managed mental health issues and singling out SAMHSA for some of that. My first questions will center upon that.

The Department of Health and Human Services is charged with leading the Federal Government's public health efforts related to mental health and substance abuse, and the Substance Abuse and Mental Health Services Administration is specifically told to promote coordination of programs related to mental illness through the Federal Government.

The Federal Executive Steering Committee for Mental Health with members across the Federal Government is designated to work on these issues, but the Government Accountability Office reports that you have not met since 2009.

HHS officials have stated that the Behavioral Health Coordinating Council, the BHCC, performs some functions previously carried about by the steering committee, yet that is limited to HHS and is not interagency.

While that sort of coordination is important, it does not take the place of or achieve the level of leadership GAO has previously found key to successful coordination and that which is essential to identifying whether there are gaps in services.

By the way, I will also point out that the Cassidy-Murphy bill creates an assistant secretary for mental health specifically charged to do this job, the interagency coordination, which has not been done since 2009.

That being the case, would you agree that HHS should raise—what are your thoughts about the Cassidy-Murphy bill? Do you think HHS should raise that profile to get that interagency coordination, which, despite being mandated, has not occurred since 2009? Thoughts?

Ms. ENOMOTO. Any effort to raise the profile of mental health issues and to increase collaboration across Federal Government is a good one. I am happy to engage in further conversation and work with you on creating a positive opportunity for that collaboration.

You noted that the FESC, the Federal Executive Steering Committee, has not met since 2009. The BHCC started meeting in 2010. Many subcomponents of the original Federal Executive Steering Committee, which had 25 components participating, do still meet, so does the Federal Executive Steering Committee on trauma, on disaster. There are also groups related to employment that have——

Senator CASSIDY. I really want to hear about mental health, and that is what appears to be what was lacking per GAO.

Let me move on, again.

Ms. ENOMOTO. OK.

Senator CASSIDY [continuing]. I have limited time.

The second report talked about the problems of a lack of evaluation for programs for the seriously mentally ill at SAMHSA. For example, of 30 programs specifically targeting individuals with SMI, 9 had a completed program evaluation, 4 had evaluation underway,

17 had no evaluation completed and none planned. I can go through but it is more like that, dismal statistics regarding those getting evaluated.

Again, I will say that the Cassidy-Murphy bill focuses on the need for evidence-based practices.

That said, recognizing that there are serious gaps and that there is need for consistency and review into monitoring programs, what is SAMHSA doing to create a better culture of evaluation at the agency?

Ms. ENOMOTO. I agree that evaluation is a really important issue. SAMHSA takes its responsibility regarding program oversight very seriously. We are continually working to improve our——

Senator CASSIDY. Can you give me a specific because I have got limited time?

Ms. ENOMOTO. SAMHSA has established a SAMHSA evaluation committee, so we are overlooking all of our programs to identify what is the right level——

Senator CASSIDY. The 17 which were not evaluated and none were planned, how do we avoid that? Why did that ever occur?

Ms. ENOMOTO. There were some challenges in terms of how those were measured, so I do not know that that is exactly the same way that we see it. However, we are committed to evaluating our programs and will continue to do so.

Senator CASSIDY. Dr. Insel, again, thank you for your service.

I have been told that the reason more National Institute of Health research funds have not been put toward mental health is that the scientific promise is not there as it might be elsewhere. You have previously noted in written documents that you have published that if you look at DALYs, disability-adjusted life years, the amount that SMI gets is below that which would normally be the main. Others like AIDS is way up here but serious mental illness is there.

I have also seen a statistics that we spend at NIH $987 for every death from suicide and $420,000 for every death from HIV, $420,000/$987. It may be too difficult. Is it worthwhile to put more dollars specifically toward the issue of suicide, knowing it is so heterogeneous? If we put more research dollars there, can we expect to see some benefit from that? Is there academic promise?

Dr. INSEL. That is a good point and a good question. How do you balance both scientific traction and burden of disease? We look at both of those in making decisions about investments. We have the traction here. It is a place where greater investment will get us greater return. We see that already when we got the Recovery Act dollars in as additional money. The results of that are spectacular. We have lots of projects that would not have happened that we can point to from Recovery Act dollars, which I think are some of the best things that this institute has done over the last decade. No question that we could use more funding in great ways.

The last issue here, just take a moment, in comparing suicide to AIDS, I want to stress the fact that that investment in AIDS could be attributed to the fact that we have reduced mortality 50 percent.

Senator CASSIDY. Totally accept that.

Dr. INSEL. It may be that we are not spending too much on AIDS but we are not spending enough on other areas like suicide prevention.

Senator CASSIDY. We will talk to the appropriators and try and get you all more.

Dr. INSEL. Thank you very much.

[Laughter.]

Senator CASSIDY. I have gone over. I yield back. Thank you.

The CHAIRMAN. Thank you, Senator Cassidy.

Senator Murphy.

STATEMENT OF SENATOR MURPHY

Senator MURPHY. Thank you very much, Mr. Chairman. Thank you to Senator Alexander and Senator Murray for taking this issue so seriously, convening us here today. Senator Alexander's comments were useful in understanding why Congress really has not taken on this issue of comprehensive mental health reform in the past because it does cut across so many agencies both latitudinally and longitudinally. It does cut across so many different committees. I really appreciate the focus on trying to get to a product that can eventually get to the floor.

A few of us were at a really interesting bipartisan briefing this morning from the Commonwealth Fund, which they were talking about the need to integrate our behavioral health systems with our physical health systems, and there were some really interesting facts that they brought out. One of them was that if you study the incidence of diabetes alone as a cost-driver and you study the incidence of mental health diagnoses alone as a cost-driver in Medicare, they are actually not that extraordinary by themselves. What makes them extraordinary cost-drivers is when they are linked together. When you have a physical health diagnosis and a mental health diagnosis together, all of a sudden you are now in that small percentage of patients that are driving cost.

Mr. Macrae, is this issue of workforce a question of not having enough providers or simply not being as coordinated as we should be between the mental health side and the physical health side? Our bill certainly is focused on this question of coordination. Where should our attack be, more providers or better-integrated providers?

Mr. MACRAE. Thank you, Senator. It is actually a combination of the two. I would say that in terms of the primary care piece, we have seen an incredible interest from our primary care providers to increase their capacity to have behavioral health providers onsite because a lot of the primary care providers have shared with us that they sometimes feel uncomfortable in terms of dealing with mental health issues. By our investments that we have made over the last several years, we have doubled the number of mental health providers that are at our health centers.

By having those providers onsite, it has actually helped our screening in terms of what we do. It has really afforded the primary care system to expand its capacity to do more. We really see it as we need to build out the primary care capacity to do more screening integrated with behavioral health.

The second part of your question about whether we have enough providers, I would say we see an incredible demand for mental health providers from our different programs. Right now, we are only able to fund about half of our applications through the National Service Corps for mental health providers. Our community health centers, 65 percent of the demand has been for behavioral health in terms of what they are requesting. We definitely see the need of both support for coordination and also providers.

Senator MURPHY. Ms. Enomoto, I want to followup on this question of HIPAA that is certainly an aspect of our bill as well. Is this a question of providers not interpreting the existing statute correctly or do we need clarification of what allows a provider to share information with a family member? Senator Collins has identified a particularly acute problem, the lack of information that goes to parents and caregivers, especially when you are talking about a young adult who may be psychotic who needs that help and assistance and that coordination. Is this a matter of needing to clarify the standard?

Ms. ENOMOTO. We believe that there are more flexibilities than many physicians and many people understand, and that clarifying the rules of the flexibilities that they have to disclose information to family members, when it is in the best interest of the patient, would be very helpful to a lot of people. We are happy to work with our colleagues at OCR and across the department to do that.

Senator MURPHY. Dr. Insel, the time in which you have been at the Institute has roughly corresponded with the period of time in which we have reduced the number of inpatient beds across the country by about 4,000, and mostly that has occurred during the recession and afterwards. There was about a 15 percent reduction.

I appreciate what you are saying in terms of the focus on trying to identify early, but can we sustain this level of continued reduction of inpatient beds over time? Is this something, as you leave, that worries you, the lack of capacity that we have to provide short-term acute-care stays for people that need a period of stabilization?

Dr. INSEL. Oh, absolutely. It is a big issue. There is no room at the end. There is no place to send patients. Often, that is why we see people being boarded in emergency rooms, which is a ridiculous situation that we find ourselves in here.

We need to look at how you extend capacity. It is not the answer to all questions, but that at least needs to be developed. I should just note that the last 13 years there has been a reduction, but the big reduction came long before that. There is over 90 percent reduction in public beds for people with mental illness since the 1970s, so a huge, huge change in what the capacity is to help people when they really need full-time support.

Senator MURPHY. This all changed in the 1960s. We did something great. We took people out of the institutions and we put them in the community, but we did two things wrong. We did not fund the support in the community, and we set up a community mental health system that was wholly separate and apart from the rest of the health care system. Hopefully, our discussion will be around those two fixes, making that promise real and bringing those two systems back to——

Dr. INSEL. That would be great. I just want to take another moment to say that we do have a system out there. It is called the criminal justice system, which has become the *de facto* mental health care system in this country. As you look at legislation, you cannot ignore that. You need to really ask, in a bipartisan way, is this the country we want to be? Is this the way that we want to treat people with a brain disorder?

Senator MURPHY. Hallelujah. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Murphy. Thanks for the time you and Senator Cassidy are spending on this issue.

The next four Senators are Isakson, Warren, Scott, and Baldwin.

Senator Isakson.

STATEMENT OF SENATOR ISAKSON

Senator ISAKSON. Thank you, Mr. Chairman.

Thank you for your testimony today.

Senator Murray, myself and Senator Cassidy are participating in a number of hearings in the VA Committee on the issue of suicide. There are approximately 22 suicides a day, 8,000 a year in our Veterans Administration for veterans of the United States. It is a crisis we are trying to deal with.

I am not a physician, nor am I a technical person, but it appears to me that in emergency room practices there is a golden hour. It is that hour from the time the accident takes place until the time the person is treated where you could save a life if somebody is in a traumatic accident.

It seems like being in terms of suicide, it is a golden minute. It is that minute when they realize they are at risk and are willing to make a call, that there is an accessible person they can get to talk to. If there is not one, then we lose people sometimes because of a lack of access to someone to talk to, to get them to an appointment, to get them to an intervention, to get them to a place where they can at least talk to a professional.

Am I right about that or am I wrong about that? Mr. Macrae?

Mr. MACRAE. I would defer to my colleague Kana, but I would say absolutely. The other piece is that early intervention is also important when you are even talking about suicide. We have had much success in terms of doing screening again in that primary care setting where you are actually able to identify children, in particular adolescents, but also veterans and other vulnerable patients where if they just had some of that intervention early on, it could make a big difference.

I know Kana can talk specifically about that golden minute.

Ms. ENOMOTO. Because of that, there is that moment that someone is reaching out for help. That is why SAMHSA has established the National Suicide Prevention Lifeline and that we have partnered with the Department of Veterans Affairs for the "press 1 if you are a veteran or a service member" so that people can access that military culturally informed type of support and then get connected with services that are in a local area to them through the telephone that is available through that phone number network.

Senator ISAKSON. Out of curiosity, has HRSA had any interaction with the VA in terms of peer review and peer process in terms of mental health?

Mr. MACRAE. Yes, we have. We have worked with them both in terms of workforce, in terms of working together to see if we can expand the mental health workforce both for the VA, as well as for a lot of the underserved programs that we work in.

In addition, we have been working very closely with them around the Veterans Choice Act in terms of that connection between the VA and some of our community health centers, for example. We are working right now on some model contract language to make that process easier so that veterans can have greater access.

Senator ISAKSON. Talking about Veterans Choice, I realize it is important for us to improve that Veterans Choice program so that golden minute can actually take place, because right now, by calling the 800-number to get the appointment and prove you are more than 40 miles away from a center takes a long time. In mental health issues, particularly suicide prevention, a long time is not a very long time and you do not need to delay that as much as possible.

It occurred to me, that our Veterans Administration's biggest problem in terms of service delivery is rural America where there are a lot of veterans and there is not a lot of health care. I know our health centers, community health centers, serve a lot of rural America. Does the VA depend on you or do you work with the VA in terms of rural environments to try and make available the professionals to help them?

Mr. MACRAE. We do. We actually right now, through the community health center, serve about 300,000 veterans across the country, and a significant number of those are actually in rural communities.

In addition, we have been partnering with the VA around telehealth in particular where we cannot actually get providers necessarily out into the rural communities but make sure that they have access through telehealth resources. That is something we have been working with, particularly in rural communities to expand the capacity for health centers to do more but also through the VA in partnership.

Senator ISAKSON. Thank you for your testimony.

Mr. Chairman, thank you for calling this hearing.

The CHAIRMAN. Thank you, Senator Isakson.

Senator Warren.

STATEMENT OF SENATOR WARREN

Senator WARREN. Thank you, Mr. Chairman.

Thank you all for being here.

With every mass shooting in this country, the American people call for action and the U.S. Congress does nothing. Instead, the deaths continue to add up with more than 30,000 people lost to gun violence during 2013 alone.

There is a lot that we could do, but according to those who object to more thorough background checks or to improved gun safety, the problem of mass shootings is a mental health problem and should be dealt with that way. When it comes time to fund mental health

research, the same people turn their backs on studying mental health problems.

Over the past 5 years, the National Institute of Mental Health's inflation-adjusted research budget has been cut by about 12 percent, and SAMHSA's inflation-adjusted budget is down about 8 percent. No one knows where this year's health budget will land.

Worse yet, even if they had adequate funding, the NIH and CDC are effectively banned from conducting research on gun-related violence. Every Appropriations bill since 1996 has included language that bans the CDC from conducting any meaningful research related to reducing gun violence.

Former Republican Congressman Jay Dickey, who is the author of that rider, wrote an op-ed 3 years ago calling for that ban to be lifted, but it remains in place year after year.

In fact, just months after the shooting in Arizona that nearly took the life of Congresswoman Gabby Giffords, Congress expanded the research ban to include NIH research as well.

Dr. Insel, let me ask you, what meaningful research that might help us better understand the connections between mental health and gun deaths and ultimately that might help us reduce gun violence are we not conducting because of Congress's ban on gun-related science?

Dr. INSEL. Thank you, Senator Warren. It is obviously a very topical and in some ways difficult issue.

The President has talked about this almost from the day after the Sandy Hook massacre when he announced the *Now Is the Time* initiative, which included a focus on just this issue.

I understand and appreciate your concern about the CDC, and of course Congressman Dickey's language has been talked about a lot in the press, and it is something that we have heard quite a bit about as well.

I should say that at NIH we have taken a somewhat different tack. Our interpretation of that language was that, well, it put a prohibition against advocating for or promoting any sort of gun control. It did not actually prohibit us from doing research on firearms and violence as a public health issue. We have continued to do that.

Last year, we announced a Request for Applications on the research on the health determinants and consequences of violence and its prevention, particularly firearm violence. That was an RFA put out by the National Institute of Alcohol Abuse and Addiction that was then joined by many, many other institutes at NIH, including NIMH. We have funded grants under that that look at issues around means restriction.

What does the science tell us about how to assess risk for someone when they have made a suicide attempt, particularly for young people who are seen in an ER? One of the grants is to understand the best way to assess their access and the best way to deal with that.

There are projects on developmental pathways of violence and substance use in a high-risk sample looking at people who we are particularly concerned about having access to weapons and whether there is a way, again, to put some sort of a scientific understanding on the question of who is most likely to get into trouble

here and what are the best interventions we can do to prevent that?

I guess in a word for us it has become—it is entirely a public health issue and is something that we feel is very much in the sweet spot of what we do at NIH in terms of trying to understand how science can save lives.

Senator WARREN. I appreciate that, and I just want to make sure I understand. You are telling me that CDC has been caught by this ban but that, in effect, NIH has found ways to work around it so that you are still conducting some research about the link between mental health issues and guns and gun violence?

Dr. INSEL. I am not going to speak to CDC because I do not know enough about what their portfolio does, but certainly, at NIH we are doing the work, and we are trying to get the science that will serve the public that is related to this issue.

Senator WARREN. I am grateful for the direction that you are trying to go.

The idea that Congress would witness children, bystanders, spouses, people watching movies, people going to church die by gun violence and refuse to take any action is irresponsible in the extreme and clearly a sellout to a powerful gun lobby.

To follow that up, with congressional inaction, by underfunding mental health research and then by refusing to support researchers who could produce fact-based nonpartisan scientific research that could help us reduce gun violence and improve our mental health system moves this Congress from irresponsible to culpable. Gun violence is tearing apart our families and our communities, and we cannot turn away from that.

Thank you.

The CHAIRMAN. Thank you, Senator Warren.

Senator Scott.

STATEMENT OF SENATOR SCOTT

Senator SCOTT. Thank you, Mr. Chairman, and thank you to the panelists for being here this morning and discussing a very important issue. Certainly, without question coming from South Carolina, I have an appreciation of the impact of mental illness and violence, mass violence in South Carolina, in Washington, and around the country as well. Certainly, we are looking forward to ways to help to reduce the impact.

Thank you for your comments on the progress that is being made at NIH on such an important issue.

You also highlighted a little earlier the *de facto* location of too many folks that are suffering from mental illness are local and county jails. Frankly, in South Carolina there are about 20,000 folks that are incarcerated and at least 3,000 have been diagnosed with some mental illness. I have heard that some studies suggest that the number could be two or three times even higher.

By default, we are finding folks incarcerated not because they necessarily committed a crime but because of their mental illness as a primary reason for their incarceration. That is something that we must address, we need to address, and frankly, from a financial perspective, one of the most expensive ways of addressing it is to

have folks incarcerated, losing their freedom at the expense of taxpayers.

Dr. Insel, you probably know that chronic mental illness cases begins for so many folks—I have heard studies suggest that at least by age 14, half of the mental illness cases have begun, and by the age of 24, three-fourths of those cases have begun. There has been a lot of conversation around intervention, early intervention, and to me it seems like the first folks that might be in the best position, if they understand what signs to look for, are the family members in the household.

Can you comment on how we remove the stigma associated with mental illness? As you have said, that we have had great success in dealing with physical illnesses from cancer and other issues because we have had the ability to put a major spotlight to reduce those challenges. How do we do the same thing in the area of mental illness?

I appreciate your service to the NIH as well.

Dr. INSEL. Thank you, Senator Scott, for that question.

I wish it was an easy one to answer. In these other medical areas, we do not have the legacy we have here of really a long era in which we either considered these not illnesses but some moral failings for individuals or, even worse, for a long time blamed families. The explanation for every mental illness was that your mother or your father did this to you, so not surprising that families have not been at the forefront of being able to turn the tide here.

The future will be largely around better education, as well as better science. We need to help people to understand that these are disorders that are like any other disorders.

As you say, the one thing that sets them apart is, unlike cancer and heart disease and most endocrine diseases like diabetes, they start in young people. These are the disorders of young people, and it makes it therefore even more touching that we do not do enough to help people grapple with them early, to give people the supports they need, to help people understand that these are real disorders and there are real treatments that we have available. Yet those treatments are not getting to the people who need them.

Senator SCOTT. Yes, sir. Thank you, sir.

Mr. Macrae, Let me just say thank you for your work with the VA in helping so many of our veterans, especially in the rural areas of our States. My brother served 32 years in the Army and worked with the Warrior Transition Unit. We have spent a lot of time focusing on the suicide-a-day issue that the military has faced. It is very heartwarming to hear someone talk about the importance and having a sense of urgency in dealing with the issues.

South Carolina is a rural State, and according to your reports, I believe we have 70 or so areas that are underserved. We looked at telemedicine as the panacea that is going to fix all the problems, but we both know that it is probably not going to fix all the problems.

Have you seen any other innovations coming our way that might give us reasons to be hopeful for challenging some of the rural areas in States like South Carolina? When I say challenging, Sometimes we have to challenge the challenges that we face in these rural areas, and frankly, with 46 counties in South Carolina, 70

underserved areas, it would be helpful to understand and appreciate any new opportunities beyond telemedicine for us to impact those areas.

Mr. MACRAE. Sure. Thank you, Senator.

Definitely, telemedicine is one of the initiatives that we are promoting quite a bit, especially in those rural communities where it can be a challenge to get those providers in. We are also looking beyond that to see if we can provide support where there are other types of providers in the community that need some assistance.

One of the projects that we have been working on recently is something called Project ECHO where we bring together academia, and basically, we bring together different communities—and we have done a lot in rural communities—to basically be able to bring cases forward and talk to someone who has more expertise in terms of that knowledge or information, and they can then use that information to then go back to their practice and provide more care.

We are definitely looking at every way we can use any other types of technologies and terms of improving health care in rural, but a lot of it, honestly, is also meeting the needs through some of our programs. The Community Health Center program has reached out into rural communities. The National Health Service Corps. is close to 50 percent. The Community Health Center program is out in rural, almost 40 percent out in the National Health Service Corps.

It is a combination of getting physical presence, telehealth where we can, and then providing support to those current providers that might need it, just that extra support. We have been doing that through this Project ECHO model.

Senator SCOTT. Thank you. I know I am out of time but one quick question, sir.

With the number of PTSD cases coming back from the military, have you found that the level of awareness and interest in mental health issues has risen substantially in the last few years?

Mr. MACRAE. Absolutely. In fact, we had been working very closely with the VA in terms of—in particular, we have been working on the Veterans Choice Act to increase the capacity, in particular in our community health centers to first identify and then also treat people with PTSD, in particular veterans. We have actually worked with them on a whole curriculum and providing guidelines to our providers to provide them that support.

Senator SCOTT. Thank you, sir.

The CHAIRMAN. Thank you, Senator Scott.

Senator Baldwin.

STATEMENT OF SENATOR BALDWIN

Senator BALDWIN. Thank you, Mr. Chairman and Ranking Member Murrray.

We know that in recent years we have made great strides in improving access to insurance coverage in this space with the Mental Health Parity and Addiction Equity Act and also the Affordable Care Act.

However, still, too many Americans face barriers to getting access to high-quality treatment options for mental health issues. I wanted to specifically hone in on eating disorders.

I hear from countless people who share their stories relating to seeking treatment for eating disorders, and they describe insurance that will not cover the care that they need. In some cases, if the plan covers this type of treatment at all, it is usually in another State and often will only cover a couple of days of residential care.

Alternatively, a plan may send them to a general psychiatric hospital or facility where the treating professionals lack the education and background about treating eating disorders.

I have teamed up with a number of my colleagues in introducing the Anna Westin Act, which aims to improve care for those with eating disorders by clarifying that mental health parity includes coverage for residential treatment services.

Ms. Enomoto and Mr. Macrae, I wonder if you can speak a little bit about the consequences when insurance companies fail to treat individuals with eating disorders and certainly other serious mental health issues in appropriate care settings by professionals who are fully qualified to address their specific disorder.

If you could tell me a little bit about what your respective agencies are doing to help improve comprehensive treatment and access for those suffering from eating disorders in their own communities, obviously, if possible.

Then, I hope to turn to a little bit more about the state of the science in this arena.

Ms. Enomoto, would you mind starting?

Ms. ENOMOTO. Thank you very much for this question because so many people do not understand that eating disorders have some of the highest mortality rates of any mental disorders and also strike very early in life from children as young as 8 years old. Access to services is critical. Denial of coverage can result in tragic outcomes for the affected patient, as well as their families.

SAMHSA is working very hard with our Federal partners at the Department of Labor and Treasury, as well as inside of HHS with Assistant Secretary for Planning and Evaluation in the Centers for Medicare and Medicaid Services to improve insurance compliance with MHPAEA, as well as to ensure parity of insurance coverage for mental disorders, including eating disorders.

We are developing informational materials for the public as well as for insurers, and we are partnering with HRSA and CMS on integrated care models such as the Primary Behavioral Health Care Integration so that we can bring the treatment for mental illness and health care together, as well as ensure that health care organizations are caring for the whole person, as you have noted is so vitally important.

Senator BALDWIN. Mr. Macrae.

Mr. MACRAE. We have two programs that are, in particular, focused on a workforce training around the whole issue of eating disorders to really increase the capacity of primary care providers to first identify and then to provide additional treatment and support and we can share that information with you if that would be helpful.

Senator BALDWIN. Great.

Mr. MACRAE. It definitely is a concern.

Senator BALDWIN. I appreciate that. Let me just continue in this vein.

The Anna Westin Act directs SAMHSA to award grants to train primary care physicians, mental health providers, and other public health professionals on early identification and intervention of eating disorders and how properly to refer patients.

Sadly, as noted, individuals suffering from an eating disorder are facing very, very high risks, and they are sort of duel, the risks of a person with an eating disorder being more likely to attempt suicide or engage in self-injury, in addition to all the physical impacts of living with and struggling with an eating disorder.

What more can SAMHSA do to increase awareness about these co-occurring mental illnesses and suicidal behavior among individuals suffering from eating disorders? Again, I would certainly invite a conversation about the current state of the science on this issue.

Ms. ENOMOTO. Yes, people with eating disorders have higher rates of co-occurring health conditions, as well as substance use and suicidality and self-injury. They are very complicated conditions to treat and manage. SAMHSA does have some specific guidance for clinicians to improve their skills and knowledge in this area for those who are interested. Unfortunately, we do not currently have any funding dedicated to improving or raising the clinical floor around eating disorders, and it is an area for potential growth.

Mr. MACRAE. I will take just a moment if I can.

The science is going great guns. The good news is that there is a new treatment called family-focused therapy, which does the opposite of what we have traditionally done. The old treatment was to take parents out of the scene. We called it a parent-ectomy. Today, we train parents and make them the focus of the treatment. The remission rates are 50 percent sustained at 2 years. This is with adolescents with anorexia nervosa—saves lives. This is a really good story.

The bad news is that very few people are at this point trained to provide that therapy with fidelity with the features of it that seem to be most effective. There is more work to do to get a workforce that actually is able to help the kids who need it.

The CHAIRMAN. I want to thank our three witnesses for your testimony.

Senator Murray, do you have any concluding remarks?

Senator MURRAY. Mr. Chairman, I just really appreciate this hearing and the participation of so many people. We are all learning as we go every day. Moving forward to make sure that we are making our health care system work for everyone has to include the issue of mental health care. I really appreciate the focus of this hearing, look forward to working with everyone.

The CHAIRMAN. Thank you.

I appreciate the attendance and involvement of so many members of the committee today. We may very well try to have another hearing on mental health before the end of the year. I will talk with Senator Murray about that and I will talk with other members of the committee about exactly how to do that.

The hearing record will remain open for 10 days. Members may submit additional information for the record within that time if they would like. The next hearing exploring issues of mental health and substance abuse disorders will be an opioid abuse hearing on Thursday, November 19th.

Thank you for being here today. The committee will stand adjourned.

[Additional Material follows.]

ADDITIONAL MATERIAL

RESPONSE BY KANA ENOMOTO TO QUESTIONS OF SENATOR ENZI, SENATOR ISAKSON, SENATOR HATCH, SENATOR ROBERTS, SENATOR MURRAY, SENATOR CASEY, SENATOR FRANKEN, SENATOR WHITEHOUSE AND SENATOR WARREN

SENATOR ENZI

Question 1. An October 5 article in the *Washington Post* described a Substance Abuse and Mental Health Services Administration (SAMHSA) contract with the public relations firm Edelman, Inc. under which Edelman sought to interview journalists—even offering to make charitable donations of $175 on their behalf—in order to learn how to refine SAMHSA's "messaging" efforts. It appears that this contract may not have been in the best interest of taxpayers.

I wrote the director of the Office of Management and Budget on October 7, requesting more information about this contract and other public relations spending by SAMHSA and other executive branch entities.

Please provide a full and complete description of the aforementioned contract with Edelman, including its purpose and terms, how much has been spent on the contract to date, and how much more is anticipated to be spent. Also provide a detailed narrative description of all spending by SAMHSA during Fiscal Year 2015 on public relations, media relations and advertising activities—both contract and in-house expenditures—including total spending and category subtotals.

Answer 1. SAMHSA takes very seriously its obligation to use taxpayer funds responsibly, especially those appropriated by Congress. This activity was in no way intended to influence reporters' coverage of SAMHSA. Given that the issues around mental health and substance abuse are complex and evolving, SAMHSA wants to ensure that our information resources were perceived as clearly, concisely and accurately as possible. Therefore, SAMHSA conducted a brief task on or about Sept 18–24, 2015, at a cost of $7,579.87. The objective was to obtain quick feedback from a handful of stakeholders and trade reporters who routinely cover behavioral health topics. The contract has expired.

The vast majority of SAMHSA's Public Awareness and Support budget is used to deliver critical resources through our Treatment Locator, crisis hotlines, website, and the publications development and dissemination. These resources inform the public and behavioral health and other health care professionals about behavioral health issues, share the latest evidence-based programs and practices, and promote prevention, treatment and recovery.

SENATOR ISAKSON

Question 1. The Secretary's announcement of plans to focus on a single medication might ignore non-opioid alternatives such as detoxification, relapse prevention followed by recovery supports. Do you agree that opioid-addicted individuals admitted should receive treatment based on their individualized clinical needs, and be provided with the option that is most appropriate for them?

Answer 1. Opioid-use disorder is a chronic disease, like heart disease or diabetes. A person with opioid-use disorder can regain a healthy, productive life. Medication-assisted treatment (MAT) is the most effective treatment option for individuals with opioid-use disorder. There are three equally important parts to this form of treatment: medication, counseling, and recovery support. These three parts work together to provide a whole-person approach to treatment. All three medications approved by the Food and Drug Administration for treating opioid-use disorder (methadone, naltrexone, buprenorphine and buprenorphine/naloxone) have been shown to be effective, safe, and cost-effective treatments when used and monitored properly by a physician and substance-use disorder professional. Research has shown that patients receiving MAT are significantly more likely to stay in treatment and significantly less likely to use illicit opioid drugs than patients who receive detoxification and psychosocial services alone. In addition, these medications lead to greater improvement in patients' social functioning, risks for overdose, risk of contracting HIV or hepatitis C, and lessen risk of criminal justice involvement. All of these medications have the same positive effect: they reduce problem addiction behavior.

When a person seeks treatment for an opioid use disorder, the first step is to meet with a doctor or other medical staff member for an individualized assessment. It is during the assessment that a doctor or substance use disorder professional discusses treatment choices with the person. This discussion empowers the person to develop an individualized treatment plan that addresses their specific needs including which medication is available and appropriate for the patient. A key component of MAT is counseling. It is through counseling that people learn about the disease of addic-

tion—why the addiction occurred, the problems it has caused, and what they need to change to overcome those problems. Counseling can also provide encouragement and motivation to stay in treatment. It can teach coping skills and how to prevent relapse. It can help people learn how to make healthy decisions, handle setbacks and stress, and move forward with their lives. The third part of MAT is recovery support. Recovery support is provided through treatment, services, and community-based programs by peer providers, family members, friends and social networks, the faith community, and people with experience in recovery. Recovery support services help people enter into and navigate systems of care, remove barriers to recovery, stay engaged in the recovery process, and live full lives in communities of their choice. Examples of recovery support services include supported employment, education, and housing; assertive community treatment; illness management; and peer-operated services.

Ultimately, MAT can help people move into healthy, addiction-free lifestyles—into a way of living referred to as recovery in which a person improves their health and wellness, live self-directed lives, and strive to reach their full potential.

Question 2. Can you discuss SAMHSA's recruitment efforts to attract and retain senior staff with medical, clinical, and direct patient care backgrounds such as psychiatric physicians or other mental health providers?

Answer 2. As a public health agency, SAMHSA employs individuals with a broad range of skills and training in order to achieve its mission and appropriately conduct activities under each of its key roles. Although SAMHSA does not provide direct clinical services, it employs numerous behavioral health professionals. Among these outstanding professionals are medical doctors and other individuals with masters and doctorates in psychology, social work, professional counseling, nursing, accounting, communications, statistics, pharmacy, and forensic toxicology, as well as individuals with bachelor's level degrees in key behavioral health fields and peer professionals.

SAMHSA is currently recruiting for a Chief Medical Officer, a position that was vacated earlier this year.

Question 3. How does SAMHSA interact with other HHS agencies and Federal departments concerning the development and implementation of mental health and substance abuse policies? What improvements—if any—could be made in this area?

Answer 3. SAMHSA works with other HHS agencies and Federal departments on the development and implementation of mental health and substance abuse policies every day.

The primary mechanism for intra-agency coordination is the Behavioral Health Coordinating Council (BHCC) which is co-chaired by the Acting SAMHSA Administrator and the Acting Assistant Secretary of Health. The BHCC coordinates behavioral health policy activities within HHS, by facilitating information sharing and collaboration across the Department. The BHCC's goal is to share information and ensure that all behavioral health issues are being handled collaboratively and without duplication of effort across the department. It has several subcommittees on topics such as serious mental illness, behavioral health quality measures, prescription drug abuse, and primary and behavioral health integration among others.

A recent example of cross-HHS work relates to the implementation of Section 223 of the Protecting Access to Medicare Act which created a demonstration project to establish certified community behavioral health clinics to deliver high-quality behavioral health care. In May, SAMHSA, in conjunction with CMS and the Assistant Secretary for Planning and Evaluation (ASPE), released a funding announcement inviting States to apply for a planning grant related to the demonstration program. The funding announcement included the criteria for States to certify Community Behavioral Health Clinics which was developed by SAMHSA and guidance on the development of a Prospective Payment System for testing during the demonstration program by CMS. ASPE has been highly engaged in both sets of guidance and will be conducting an evaluation of the program. In October, SAMHSA awarded planning grants to 24 States and 8 States will begin a Medicaid demonstration program in 2017.

At the interdepartmental level, there are also a number of coordinating bodies that focus on the needs of individuals with mental illness and substance use disorders. For example:

- SAMHSA leads the Federal Working Group on Suicide Prevention and co-manages the National Suicide Prevention Lifeline with the U.S. Department of Veterans Affairs (VA);

• SAMHSA serves as the HHS lead for the Interagency Task Force on Military and Veterans Mental Health, which is tasked with implementing the President's Executive order related to military, veterans and their families' mental health;
• SAMHSA provides leadership for the Federal Partners Committee on Women and Trauma;
• SAMHSA also recently co-chaired two committees of the National Heroin Task Force which was convened by DOJ and ONDCP and produced a Final Report on December 31, 2015.

SENATOR HATCH

Question. As you know, the United States is in the midst of a severe opioid abuse epidemic. In 2013 alone, approximately 1.9 million Americans met the diagnostic criteria for abuse or dependence on prescription pain relievers.

Given the severity of the opioid addiction epidemic, what role do you think Medication Assisted Therapy should have in combating the problem?

Answer. Research has shown that a comprehensive approach to treatment yields the best results. By combining the different components of treatment, such as withdrawal management, use of FDA-approved addiction pharmacotherapies—otherwise referred to as Medication-Assisted Treatment (MAT)—counseling, and recovery support in a manner that is individualized to meet the needs of the individual, the best possible outcomes can be promoted. These outcomes include reduced death from overdose, reduced infection with HIV and Hepatitis C, improved social functioning, and reduced criminal activity. To accomplish this MAT needs to be available in all its forms wherever people seek treatment. Persons with opioid use disorder need access to all forms of effective therapy in the same way that someone with diabetes needs to be treated with the medication that will work best for him or her.

SENATOR ROBERTS

Question 1. Access to substance abuse and mental health services and treatment in rural States like Kansas continues to be a problem. What is being done to address this within your respective agencies?

SAMHSA'S COMMUNITY MENTAL HEALTH BLOCK GRANT.

Answer 1. A regional model is being used for allocation of SAMHSA's Community Mental Health Block Grant (MHBG) funds for Kansas. The Regional Model brings specialized and evidenced-based services to every region including rural areas. This approach equips the mental health system to serve a wider variety of challenges through collaboration, capacity building and resource sharing among the individual Community Mental Health Centers (CMHCs) that comprise the region. This also will expand the mental health system's funding by leveraging MHBG funds with other resources to accomplish long-term goals. Last, this approach encourages a systemic perspective, which creates potential for more efficiency and more cost savings.

Kansas has contracted with three Managed Care Organizations (MCO) to provide children and families greater choice of care. This also ensures a child and their family's timely access to services and a provider within a specified timeframe in rural, semi-urban and urban communities across the State. With the MCO's in place this will also increase the accountability of our system. The MCO's will be capable of identifying gaps and barriers within our system.

On July 1, 2014 Health Homes for people with serious mental illness were implemented as Kansas believes that they are a critical core component of the positive health outcomes expected from KanCare. The comprehensive and intensive coordination of care provided by Health Homes will result in positive outcomes for KanCare members who experience chronic conditions such as serious mental illness (SMI) or diabetes.

Health Homes will ensure that:

• Critical information is shared among providers and with Health Home consumers;
• Members have the tools they need to manage their chronic conditions;
• Critical screenings and tests are performed regularly and on time;
• Unnecessary emergency room visits and hospital stays are avoided; and
• Community and social supports are in place to help Health Home consumers stay healthy.

There are 26 licensed Community Mental Health Centers (CMHCs) that currently operate in the State. These Centers have a combined staff of over 4,000 providing mental health services in all 105 counties of the State. Together they form an integral part of the total mental health system in Kansas. Each of the 26 licensed

CMHCs operating in Kansas has a separate duly elected and/or appointed board of directors. Each of these boards is accountable to the citizens served, its county officials, the State legislature, and the Governor; and all have reporting responsibilities to the national level of government. The primary goal of CMHCs is to provide quality care, treatment and rehabilitation to individuals with mental health problems in the least restrictive environment.

The Centers provide services to all those needing it, regardless of their ability to pay, age or type of illness. The Centers strongly endorse treatment at the community level, to allow individuals to experience recovery and live safe, healthy lives in their homes and communities. Staff are assigned to assist and support the development of funding programs for children and families which includes the Youth Leaders in Kansas Program (YLinK). This program is for youth ages 12 to 18; with the support and guidance of their parents/guardians; to support them with information, education and development of individual and group leadership skills in their community, statewide and nationally. They also oversee the Family Care Treatment (FCT) which was replicated from the Oregon Model of Intervention with Antisocial Youth and their Families. This program trains therapists in providing interventions to youth who are experiencing severe challenging behaviors which threaten their continued success in a family setting and their families who reside in Kansas to increase their pro-social behaviors and their families' ability to positively support them. The target population of this effort is children who have had or are at serious risk of having multiple foster care placements and/or children referred to State hospitals or other in-patient treatment or Juvenile Justice Programs due to severe challenging behaviors.

In 2015, the needs assessment focused on transitional care services. The housing options assessed include the following:

- Emergency Shelter—Any facility whose primary purpose is to provide temporary shelter for the homeless in general or for specific populations of the homeless.
- Interim Housing—Short-term (up to 6 months) project-based housing that provides immediate community-based housing for persons who are homeless or who are homeless and being discharged from inpatient or residential mental health or substance use treatment facility (e.g., a State psychiatric hospital (SPH), nursing facility for mental health (NFMH), substance use disorder (SUD) treatment facility or community hospital inpatient psychiatric program.
- Structured Care Living Environment—Short-term residential facility providing a safe, structured environment for individuals with high psychiatric needs. Services are available 24 hours per day and are offered according to clinical need. The facility can be owned or leased by the CMHC or owned by a community organization. Length of stay in the facility is short term and is no more than 6 months.
- Housing Vouchers—Short-term financial assistance used to temporarily place an individual or family in a hotel following discharge from an institution.
- Transitional Housing Beds—Short-term housing beds coupled with supportive services. Short term stays can be defined as residing in the beds for up to 6 months; 6 months—1 year, or 1–2 years.
- Rapid-Rehousing—Programs to assist individuals and families who are homeless move as quickly as possible into permanent housing and achieve stability in that housing through a combination of short-term rental assistance and supportive services.
- Housing Placement Services—Services to help people find permanent housing after discharge from the transitional housing option.

EVIDENCE-BASED PRACTICES FOR EARLY INTERVENTION

Kansas utilized the Mental Health Block Grant 5 percent set aside to develop and issue a Request for Proposal (RFP) that was for eligible applicants from one of the 26 Community Mental Health Centers (CMHC) within the State for competitive bid. The RFP would create a pilot for establishing a Coordinated Specialty Care (CSC) program designed to provide early interventions services for persons experiencing first episode psychosis (FEP). The proposals provided for early episode Serious Mental Illness (SMI) interventions; including early psychotic disorders which incorporate the Recovery After an Initial Schizophrenia Episode (RAISE) model of intervention and supports by NIMH.

Funds are used to serve individuals with a serious mental illness who within 1 week to 2 years have experienced their first episode of psychosis. The age range of the target population is 15–25-year-olds. The diagnosis that is used for inclusion in the program, following the recommendations of the RA1SE model, include: schizophrenia, schizoaffective disorder, schizophreniform disorder, brief psychotic disorder,

psychosis not otherwise specified and delusional disorder. Funds were awarded to Wyandot Center for Community Behavioral Healthcare, Inc. in 2015. Wyandot has established an Early Intervention Team (EIT) and has completed all required trainings. They began accepting participants in the program in April 2015. From April 1st to May 31st there were 19 referrals; 6 were accepted into the program and 13 were pending at the time of the last report.

SAMHSA'S DISCRETIONARY GRANTS

SAMHSA currently has 13 discretionary grants in Kansas that include programs to promote statewide family networks, statewide consumer networks, data infrastructure, suicide prevention, early childhood education and referrals, jail diversion, Tribal behavioral health, and Mental Health First Aid. These grants ensure a wide range of support for mental health treatment and services in Kansas.

MEDICATED ASSISTED TREATMENT (MAT)

SAMHSA conducts a number of activities to address barriers to MAT in rural States. These include technical assistance to opioid treatment programs and support in opening and operating medication units to reduce the burden of travel for persons receiving care in programs serving large geographic areas. The Provider Clinical Support System for MAT provides training and mentors to health professionals in rural States to working in isolation or new to the area of addiction treatment in order to increase adoption of evidence-based practices and delivery of high-quality care. SAMHSA is piloting a collaborative learning community for providers using the Extension for Community Healthcare Outcomes (ECHO) model designed for improving access in rural States so busy providers without access to academic or specialty consultation can acquire the skills they need to manage challenging patients in their communities. In addition, in 2015 SAMHSA awarded 11 grants for the Targeted Capacity Expansion: Medication Assisted Treatment-Prescription Drug and Opioid Addiction (MAT–PDOA) to States partnering with hard hit communities to develop MAT and the counseling and ancillary services necessary for MAT to be most successful. Two of the grants were awarded to rural States, Iowa and Wyoming.

Question 2. I have heard about the VA utilizing people called Peer Support Specialists to help and support individuals with mental health and substance use conditions. How are SAMHSA and HRSA utilizing peer support specialists and what more can be done to expand their use in the private sector?

Answer 2. SAMHSA and HRSA have been working closely together to explore the increased use of peer support specialists in a wide variety of integrated behavioral and physical health care settings. We have collaborated to explore the documentation of promising practices including such issues as scope of practice, certification standards, reimbursement strategies, and ongoing training. In addition, through the Behavioral Health Workforce Education and Training Grants offered in academic year 2014–15, SAMHSA and HRSA have supported the training of 960 students in a variety of paraprofessional certificate programs, including peer professional programs. The utilization of peer support specialists in States across the country is a fast expanding area of employment.

SAMHSA's Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) aims to build resilience and facilitate recovery by developing, promoting and disseminating effective policies and practices to support the development and expansion of addiction and mental health recovery support initiatives and strategies. Through BRSS TACS, SAMHSA provides policy/data analysis, training, technical assistance, and needed information tailored to the perspectives of States, counties, behavioral health systems officials and providers, including consumer/peer providers, family members, and other stakeholders in recovery-oriented services and systems.

SAMHSA in conjunction with diverse stakeholders and subject matter experts from the mental health consumer and substance use disorder recovery movements developed the first integrated guidance on core competencies for peer workers with mental health and substance-use lived experience. These competencies provide guidance for the development of initial and on-going training designed to support peer workers' entry into the peer workforce and continued skill development.

SAMHSA has also offered funding and planning assistance to States, territories and tribes or tribal organizations to develop and implement actions plans that engage peers; funded two subcontracts to peer-run and recovery community organizations. One subcontract supports education, planning, and implementation of recovery supports. A second aims to build the capacity to implement statewide outreach

and dissemination efforts that increase knowledge of health care policies and activities; and provided training and technical assistance to promote further adoption and implementation of recovery supports and services nationwide.

BRSS TACS has:

• Disseminated training and technical assistance products about the benefit of peer services to approximately 4,799 people nation-wide who have opted in to receive messages from SAMHSA BRSS TACS about the benefit of peer services and recovery coaching.

• Funded 26 peer subcontracts in amounts up to $40,000 for an estimated total amount of $1 million to peer-run/recovery community organizations to promote the adoption of peer-delivered, recovery-oriented services for people in recovery.

• Funded 43 peer subcontracts in amounts up to $40,000 for an estimated total amount of $1.7 million to peer-run/recovery community organizations to build the capacity to implement statewide outreach and dissemination efforts that increase knowledge of health care policies and activities, and changes in health care systems and services for people in recovery from mental health and/or substance use disorders.

• Funded 30 State planning subcontracts to behavioral health authorities in designated State, territories and tribes in the amount of $50,000 for an estimated total amount of $1.5 million for the development of peer specialist/recovery coach programs, the expansion of peer-operated services, establishment of shared-decision-making approaches and the initiation of supported employment programs.

• Funded four annual State policy academies to 25 State teams participating in amounts up to $75,000 for an estimated total amount of $1.8 million to assist States, territories and tribes or tribal organizations to develop and implement actions plans that engage peers, address development of system, service provision, and treatment approaches for more effective utilization of all Federal, State and local funding sources and resources in addressing the goals and objectives of SAMHSA's Recovery Support Initiative. One additional State Policy academy will include five jurisdictions in 2016.

Although SAMHSA's current activities contribute the expansion of recovery supports and services by peer-run/recovery community organizations, and more effective utilization of funding sources in systems, service provision and treatment approaches within the States, some of these practices can be shared collaboratively with the private sector. One natural place to begin is with organizations or entities in the private sector that exist in the communities served by SAMSHA and Federal partners.

Examples of milestones to consider include an increase access to care, integrate delivery of recovery-oriented services and supports, and increase coordination of effective eservices across systems. Recipients of the subcontracts to peer-run/recovery community organizations to receive or provide technical assistance may also work in public and private sectors. For example, Project Return Peer Support Network in California led an initiative to reduce negative perceptions about mental health by training peers to effectively share experiences in recovery using a stigma and discrimination model in Latino communities.

BRSS TACS has also hosted training and provided technical assistance for efforts and innovations that support and promote peer services and inclusion of peers in the behavioral health workforce. Examples include SAMHSA's establishment of a new strategic initiative focused on workforce issues; the development of a set of core competencies for peer providers; and the development of national practice guidelines for peer providers. Skills acquired can be applied to both sectors.

In June 2015, SAMHSA/CMHS held a 2-day dialog meeting to discuss the financing of recovery support services, including peer services, in the public and private sectors. A variety of stakeholders from both sectors participated in this dialog discussing/exploring ways to (1) expand access to treatment for serious mental illness (SMI) and co-occurring disorders and access to recovery support services with evidence-based practices (EBP) to improve outcomes and (2) further engage the private sector in financing. This dialog not only forwarded the discourse on recovery support services between public and private stakeholders, but also yielded several short- and long-term recommendations. A summary of the meeting will be published in the next few months.

SAMHSA/CSAT promotes the utilization of peer support specialists/peer recovery coaches through several grant funding initiatives that build the capacity of community-based, faith-based organizations and State substance abuse treatment systems and other allied health systems to employ peer support specialists/peer/recovery coaches , as well as to train and certify peer support specialists/peer/recovery coaches that expand the behavioral health workforce and reach beyond clinical treatment

into the individuals every day environment. Since 1998, SAMHSA/CSAT has funded over 104 programs across the Nation and in tribal communities to train and employ peer support specialists/peer/recovery coaches , and to provide peer recovery support services in local communities and in behavioral health treatment systems. SAMHSA/CSAT also supports the use of peer specialists in discretionary grant programs of adolescent treatment, criminal justice re-entry, including drug courts, and in supportive housing grants. Peer support specialists/recovery coaches could be expanded and enhanced through a comprehensive training and certification network that is supported and monitored through a Peer Specialist guild that provides oversight to training, supervision ethical codes of conduct, practice standards, and competencies for the work of peer specialists/recovery coaches. Unlike other professions, peer practice through certification and other standards vary among States and forms of reciprocity across States and health care systems do not exist. The private sector can benefit the work of the peer specialist/recovery coaches through the promotion of a career ladder that may have varying specializations for work in specialty areas as forensics, healthcare, children and youth, etc.

Use in the private sector could also be expanded by support from standardization of funding mechanisms. For example, some States support Medicaid reimbursement of peer specialists/recovery coaches in certain settings, whereas other States do not reimburse for the same "peer specialist" service. Likewise, there is discrepancy across disciplines. Often the mental health discipline is able to reimburse for peer support specialists when equally trained peer support specialists or recovery coaches in the substance use disorder field are not considered "reimbursable."

Question 3. The number of individuals dying by suicide continues to increase. Please tell me what the agency is doing to help individuals in crisis and connect them with care so we can save lives?

Answer 3. SAMHSA is very concerned about the increasing number of suicides in the United States. Much of this increase is in suicides among adults: from 1999 to 2010, the suicide rate among middle-aged Americans (35–64) rose significantly, by 28.4 percent (Centers for Control and Prevention. *MMWR* 2013;62:321–3). The largest number of suicides is also among adults: CDC's recently released 2014 mortality data show that 87 percent of the suicides in this country are among adults (aged 25+).

In contrast, the majority of community-based federally funded suicide prevention programs focus on young people. Currently the United States supports a major effort in youth suicide prevention at SAMHSA through the Garrett Lee Smith Memorial Act, as well as the Tribal Behavioral Health Program, both of which focus on young people through age 24, which have demonstrated effectiveness in reducing youth suicide attempts and fatalities. The Departments of Veterans Affairs and Defense implement significant efforts for their specific populations, veterans and active duty military. Our sister agencies NIH (NIMH) and CDC conduct research and surveillance, both of which are vital for effective suicide prevention work. However, there is no major national suicide prevention program aimed at adults, with the exception of SAMHSA's small National Strategy for Suicide Prevention grants (currently funded at $2M, proposed at $4M in the President's fiscal year 2015 and fiscal year 2016 budgets).

The National Suicide Prevention Lifeline (Lifeline), which serves all ages, is a major life saving crisis intervention resource that can be accessed anywhere in the country at any time of the day or night. Over 160 crisis centers across the country receive calls from the Lifeline and in the past year the Lifeline answered over 1.5 million calls. SAMHSA evaluation studies have shown that approximately 25 percent of these calls are from individuals who are actively suicidal at the time of the call. The Lifeline, which can be reached at 1–800–273-TALK (8255), also provides access to the Veterans Crisis Line through an agreement with the Veterans Health Administration.

SAMHSA places major emphasis on improving the care of both youth and adults in crisis by working to improve followup services after someone who has attempted suicide is discharged from inpatient units and emergency rooms. These are times of very high risk where studies have shown that intervention, especially assisting people transition to the next level of care, can save lives. Improving such care transitions is a requirement of SAMHSA's Garrett Lee Smith and National Strategy grants, and SAMHSA has provided small grants to a cadre of Lifeline crisis centers to assist them in providing these services. In addition, SAMHSA is working with the National Action Alliance for Suicide Prevention on promoting and implementing comprehensive crisis intervention services, as well as on improving care transitions.

SENATOR MURRAY

Question 1. Integrating mental health care with primary care is critical to Washington State's effort to reform the health care system. One project in particular is making a big difference in the lives of patients with mental illness. The Washington Mental Health Integration Program is a partnership between the University of Washington AIMS Center has partnered with Community Health Plan of Washington throughout the State and expanded to additional sites in King County by working with Seattle and King County Public Health. It has promoted an evidence-based model for collaboration between primary care and mental health providers to hundreds of community health centers across the State serving more than 50,000 patients with mental health and substance use disorders. I know that there are many similar projects underway across the country.

How are SAMHSA and HRSA supporting the integration of mental health and primary care? How are community health centers helping to support this work?

Answer 1. SAMHSA's Center for Mental Health Services recently awarded an additional 60 grants for Primary and Behavioral Health Care Integration (PBHCI) bringing the total number of active grantees to 121. 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. An estimated 75 percent of the active PBHCI grantees partner with a federally Qualified Health Center to provide onsite primary care services. Grantees are working toward integrating primary and behavioral health care services in their facilities.

The SAMHSA–HRSA Center for Integrated Health Solutions (CIHS) promotes the development of integrated primary and behavioral health services to better address the needs of individuals with mental health and substance use conditions, whether seen in specialty behavioral health or primary care provider settings. CIHS is funded jointly by SAMHSA and HRSA.

CIHS provides training and technical assistance to community behavioral health organizations, community health centers, and other primary care and behavioral health organizations.

The Primary and Behavioral Health Care Integration (PBHCI) grant program helps prevent and reduce chronic disease and promote wellness by treating behavioral health needs on an equal footing with other health conditions.

CIHS support increases the number of:

- Individuals trained in specific behavioral health-related practices;
- Organizations using integrated health care service delivery approaches;
- Consumers credentialed to provide behavioral health-related practices;
- Model curriculums developed for bidirectional primary and behavioral health integrated practice; and,
- Health providers trained in the concepts of wellness and behavioral health recovery.

CIHS has a number of resources available that outline the need for integrated health services and the barriers to achieving these models. A selection of key resources is included below:

- *Evolving Models of Behavioral Health Integration in Primary Care:* Summarizes the available evidence and States' experiences around integration as a means for delivering quality, effective physical and mental health care.
- *Behavioral Health Homes for People with Mental Health & Substance Use Conditions:* Core Clinical Features: Proposes a set of core clinical features of a behavioral health home (i.e., a behavioral health agency that serves as a health home for people with mental health and substance use disorders). The report provides context to the development of the health home option and its relationship to the person-centered medical home; outlines established principles of effective care and the chronic care model for serving people with chronic illnesses; applies the chronic care model as the framework for the behavioral health home's clinical features; and describes multiple organizational models for structuring the behavioral health home.
- *Reimbursement of Mental Health Services in Primary Care Settings:* Identifies the barriers to successful provision and reimbursement of mental health services by practitioners in primary care settings.
- *Strategies for Integrating and Coordinating Care for Behavioral Health Populations: Case Studies of Four States:* Provides case studies of four State programs that harnessed different funding streams and used a variety of strategies to organize and deliver care.

Integration of Mental Health Substance Use and Primary Care: Addresses the evidence for integration of mental health services into primary care settings and primary services into specialty outpatient settings through a comprehensive systematic review.

Question 2. Behavioral health crises are a critical time for individuals with mental illness or substance use disorders. Individuals in crisis and their loved ones don't always know where to turn. Local governments, States, and community organizations work hard to coordinate responses but our fragmented health care system complicates this work.

What resources do communities need to improve care coordination when someone experiences a behavioral health crisis? What additional support do individuals and families need so that they know where to turn in a crisis situation?

Answer 2. In 2014, SAMHSA examined the effectiveness and costs of a number of psychiatric emergency services to stabilize and improve psychological symptoms of distress and to engage individuals in the most appropriate course of treatment. In contrast to the traditional hospital inpatient-based care settings available to individuals in need of immediate attention for psychiatric or substance abuse symptoms, crisis services include an array of services that are designed to reach individuals in their communities through telephone hotlines or warm lines, and mobile outreach; and to provide alternatives to costly hospitalizations—such as short-term crisis stabilization units and 23-hour observation beds.

Over the past year, input from consumers and their families, crisis responders, and system administrators through webinars, interviews, focus groups, and expert panel meetings, has elaborated the elements of a comprehensive response system and how components of the system should work together. A continuum of services has emerged that follows a public health model (prevention, early intervention, intervention/stabilization and post-vention), beginning with the individuals' and/or their families' initial experiences of crisis and extending to more intrusive and costly interventions.

- Prevention: access to quality behavioral health care treatment; housing education, social supports, peer and family supports, wellness recovery action plans (WRAP), psychiatric advanced directives (PAD), and family psycho-education.
- Early Intervention: warm lines, hotlines, mobile crisis outreach, Open Dialogue model interventions, and respite services.
- Intervention and Stabilization: recovery centers; 23 hour crisis stabilization; mobile crisis teams; Crisis Intervention Teams (Police CIT); detox centers; short-term crisis residential; Emergency room and inpatient settings.
- Post-vention: assessment/reassessment of services and supports; WRAP post crisis planning, transitional support including case management, family support, and peer bridgers.

Effective crisis response systems are dependent upon the adequacy of the community behavioral health system in which they are embedded. Individuals with access to an adequate array of behavioral health services are less likely to require more intensive, expensive and potential traumatizing emergency room visits and hospitalizations. The better the community behavioral health system, the more likely that it can prevent a crisis from occurring in the first place or provide low cost and less intrusive practices to address the crisis. Similarly, after the emergency room or hospitalization occurs, post-crisis or bridging services and supports are needed to prevent recurrence. The most effective crisis response systems are understood as vital components of the larger community behavioral health services and not separate or parallel systems accessed only to execute detentions and hospitalizations.

While most States have some components of the continuum, the entire continuum of services, is not universal across the country or even across a state. Prevention activities, particularly wellness recovery action plans (WRAP), psychiatric advanced directives (PAD), and family psycho-education can enable consumers and their families to respond to crises with greater self-efficacy.

Question 3. As the author of the Children's Recovery from Trauma Act, I am a strong supporter of the National Child Traumatic Stress Network. This program—administered by your agency—supports a nationwide network of centers that provides evidence-based treatment, services, and training related to child trauma. One of the strengths of this program is its broad emphasis on evidence-based care for children recovering from trauma. The bipartisan Mental Health Awareness and Improvement Act, seeks to strengthen this work.

How does SAMHSA intend to continue to support the Network and emphasize evidence-based care? What are some examples of how SAMHSA will strengthen the network's work?

Answer 3. SAMHSA's National Child Traumatic Stress Initiative (NCTSI) grant program is a leader in developing and disseminating evidence-based trauma treatment, consultation, training and other information to address child traumatic stress. SAMHSA continues to actively work to support the National Child Traumatic Stress Network (NCTSN) as the Nation's key resource for evidence-based child trauma information for families, providers and other stakeholders. SAMHSA is in the process of issuing Funding Opportunity Announcements (FOAs) for up to 78 fiscal year 2016 grant awards that will continue and expand the work and impact of the NCTSN. SAMHSA staff is engaged in ongoing linkage with NCTSN leadership, through participation in the NCTSN Steering Committee, the NCTSN Advisory Board, and regular calls with leadership of the National Center for Child Traumatic Stress. As a result, new opportunities and ongoing commitments to improve or expand NCTSN impact are discussed, developed and implemented.

A unique role SAMHSA plays in strengthening the work of the Network is that of bringing the essential work and benefits of the NCTSN to the awareness of Federal partners who are helping to disseminate Network information and resources broadly. Through linkages with the Agencies such as the: Administration for Children and Families (ACF), Centers for Medicare and Medicaid Services (CMS), Federal Emergency Management Agency (FEMA), and the Department of Justice (DOJ), SAMHSA's child trauma knowledge, experience and resources are routinely benefiting children, adolescents and families in the child welfare, Medicare and Medicaid, Disaster Response, and Juvenile Justice systems respectively, throughout the country. SAMHSA will be working to sustain established connections, such as those with ACF, FEMA and the DOJ, and build additional Federal linkages.

An example of a newer collaboration is the provision of NCTSN-developed information on the assessment and treatment of complex trauma to support the CMS Health Homes program. SAMHSA staff has been an active intermediary, from clarifying options that could support CMS to reviewing technical assistance materials that will support States that may wish to prioritize child trauma in their Health Homes services.

SAMHSA has developed and increased the public awareness emphasis around the serious impact of child traumatic stress. In May 2015, the campaign, "National Child Traumatic Stress Initiative (NCTSI): Helping Children Recover and Thrive" launched a new website full of resources at *www.samhsa.gov/child-trauma*. This campaign included the creation of a new infographic titled, 'Understanding Child Trauma." SAMHSA also released two NCTSI child trauma educational public service announcements (PSA's) at this year's National Children's Mental Health Awareness Day event in May 2015. These PSA's entitled, Bounce and Notice, are available in both English and Spanish. To date, the NCTSI's Helping Children to Recover and Thrive Campaign PSA's have reached over 96 million viewers online and radio airings have reached over 157 million. Network Members have been instrumental in helping to create campaign products and in distributing the materials of the campaign.

Question 4. "Conversion" therapy, or so-called "reparative" therapy, is a practice that falsely claims to change a person's sexual orientation or gender identity. This practice has been widely discredited by nearly all major American medical, psychiatric, psychological, professional counseling, educational, and social work professional organizations. Most concerning are the effects on children and youth, which can include guilt, anxiety, and societal rejection that negatively impacts healthy development. State legislatures across the country have also banned the practice including California, New Jersey, Oregon, Washington, and the District of Columbia.

What steps has SAMHSA taken to address conversion therapy and protect young people?

Answer 4. In October 2015, SAMHSA published a report on positive and appropriate ways to address distress related to sexual orientation, gender identity, and gender expression with children, adolescents, and their families. This report, which was developed in collaboration with the American Psychological Association and a panel of behavioral health experts, is the first Federal in-depth review of conversion therapy. As SAMHSA reported, variations in sexual orientation, gender identity, and gender expression are normal. Conversion therapy is not effective, reinforces harmful gender stereotypes, and is not an appropriate mental health treatment.

SAMHSA is working with partners to broadly disseminate this information to providers and other stakeholders. As part of the initial dissemination efforts, SAMHSA staff partnered with the White House on the release of the report and joined White House officials such as Senior Advisor Valerie Jarrett and Office of Public Engagement LGBT Lead Aditi Hardikar for a press call, Tumblr chat and Rural Summit.

Question 5. Improving the quality, affordability, and accessibility of health care remain top priorities, especially in the treatment of individuals with mental illness or substance use disorders. Experts are evaluating the impact of access to mental health facilities that integrate: (1) crisis stabilization services, (2) inpatient beds, (3) peer-to-peer counseling, and (4) onsite partnership with community health organizations.

Experts are looking for nationally replicable models that incorporate these elements and seek to integrate their services with housing assistance, professional development, community health centers, and support groups.

How many facilities currently exist nationwide that include: (1) crisis stabilization services, (2) inpatient beds, (3) peer-to-peer counseling, and (4) onsite partnerships with community health organizations?

At the Federal level, what barriers exist for the replication and expansion of this model? How does the supply of health care professionals and associated training costs affect expansion of the model? How do Federal payment systems encourage the expansion of this type of model of care?

Answer 5. To answer these questions, data was pulled from several tables drawn from the 2010 National Mental Health Services Survey (NMHSS) report—the most recent year for which these data are available. More information about the survey can be found online at: *http://www.samhsa.gov/data/mental-health-facilities-data-nmhss/reports*.

It is important to note that the survey does not report on the number of facilities that offer all four types of services in combination. Further, the survey does not collect data on onsite partnerships with community health organizations.

Table 2.15 shows the number and percent of facilities in the United States that employ a crisis intervention team, by facility type, for 2010. A total of 5,295 (57.9 percent) facilities reported having a crisis intervention team. 2,157 (23.6 percent) facilities had a crisis intervention team only within the facility; 951 (10.4 percent) had a team only offsite; and 185 (23.9 percent) had a team both within the facility and offsite.

Table 2.2 shows the number of inpatient mental health treatment beds in facilities providing 24-hour hospital inpatient care, by facility type, for 2010. A total of 1,975 (19 percent) facilities reported having inpatient mental health treatment beds, representing a total of 99,493 clients and 113,569 beds as of April 30, 2010.

Tables 2.11a and 2.11b show the number of facilities offering consumer-run services (i.e., peer-to-peer counseling) as part of their supportive services and practices. A total of 1,849 (18.5 percent) facilities reported that they offer consumer-run services.

Also in response to this question, SAMHSA also did an outreach to behavioral health organizations to identify case examples of facilities that provide all of the following services addressing both substance use disorders and mental illness: (1) crisis stabilization services; (2) inpatient beds; (3) peer-to-peer counseling; and, (4) onsite partnerships with community health organizations.

The following is a list of some barriers that may impact the replication and expansion of integrated models of care.

- Regulatory siloes that discourage integration of substance use and mental health services;
- Reimbursement rates for services provided, including those provided by peer specialists;
- Compliance with behavioral health insurance parity;
- Workforce shortages in specialty care, in particular with psychiatry;
- Long term sustainability;
- IT infrastructure that allows for seamless integration of substance use, mental health and physical health information;
- Tools to measure consumer experiences and outcomes;
- Access to mobile applications to concurrently support recovery;
- Prejudice and discrimination toward individuals with mental illnesses and addictions; and
- System fragmentation.

Serious workforce shortages exist for health professionals and paraprofessionals across the United States. For example:

- In 2011, there were only 2.1 child and adolescent psychiatrists per 100,000 people and 62 clinical social workers per 100,000 people across the United States.
- Sixty-two million people (20–23 percent) of the U.S. population live in rural or frontier counties; 75 percent of these counties have no advanced behavioral health practitioners.

• In 2012, the turnover rates in the addiction services workforce ranged from 18.5 percent to more than 50 percent. (SAMHSA Website)

The shortage of health care professionals and the associated costs with training and educating a competent and qualified workforce impact the ability to develop new models of care.

The Medicaid Health Home model supports integration of behavioral health in alignment with the Triple Aim of improving healthcare, containing costs, and improving health outcomes. The four principles which are highlighted in the SAMHSA–HRSA report, *Behavioral Health Homes for People with Mental Health & Substance Use Conditions: Core Clinical Features* include: person-centered care; population-based care; data-driven care and evidence-based care.

SENATOR CASEY

Question 1. As a member of the Senate Finance Committee as well as the HELP Committee, I frequently hear about mental health and the child welfare system.

Given the importance of screening for mental illness early, do any of the efforts funded by SAMHSA work to ensure that children who enter the foster care and adoption system are screened for mental illness and referred to appropriate treatment?

Answer 1. SAMHSA has had, and continues to have, partnerships with the Administration for Children and Families (ACF) to address the mental, emotional, and behavioral issues for youth in the foster care and adoption systems.

In 2012, SAMHSA was instrumental in hosting a 2-day meeting, "Domestic and International Adoption: Strategies to Improve Behavioral Health Outcomes for Youth and Their Families," to discuss science, policy, and practice related to behavioral health challenges of children who have been adopted and their families. The interagency planning committee for the meeting included representatives from the Administration for Children and Families, Centers for Disease Control and Prevention, National Institute on Alcohol Abuse and Alcoholism, National Institute on Drug Abuse, National Institute of Mental Health and the National Institute of Child Health and Human Development. The meeting provided an interdisciplinary opportunity for participants to share knowledge and discuss implications for future research, practice, and policy.

Based on the meeting, and subsequent work, on January 28, 2015, SAMHSA published the document, "Domestic and International Adoption: Strategies to Improve Behavioral Health Outcomes for Youth and Their Families." This document provided a summary of the expert panel meeting, along with suggestions for future action in the areas of research, practice and policy (see *https://www.samhsa.gov/sites/default/files/children-2015-domestic-international-adoption-strategies.pdf*).

In February 2015, SAMHSA also produced a webisode (Internet television show) on the behavioral health needs of children, youth, and young adults who have been adopted. (The Adoption Webisode is available at *www.samhsa.gov/children). The archived webisode was promoted to behavioral health and adoption organizations throughout the country.*

In addition to this work, SAMHSA also continues to provide direct services in the form of assessment and treatment to youth in the foster care system as part of the Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances program (also known as the Children's Mental Health Initiative or CMHI). In fact, youth in foster care is one of the priority populations for this program, which has resulted in specialized approaches from grantees across the country. Data from the national evaluation indicate that over 15 percent of referrals for this program come directly from the child welfare system, and outcome data demonstrate that significant improvements occur in the areas of mental, emotional and behavioral functioning. Because of the importance of this population, SAMHSA has had an Interagency Agreement with ACF to provide technical assistance specifically designed to address the needs of youth in foster care. The importance of this activity is further demonstrated by having a specific task for child welfare technical assistance in the recently awarded contract for a National Training and Technical Assistance Center (NTTAC).

SENATOR FRANKEN

Question 1. The Mental Health Parity and Addiction Equity Act passed in 2008. Seven years later we are still waiting for the law to be fully implemented. The consequences are dire. A recent report by the National Association of Mental Illness (NAMI) reported that:

1. Even with insurance many people continue to struggle finding therapists within their network;

2. The claims for mental health treatment are more often denied than those for a physical disease; and

3, Medications for mental illness carry higher copayments. There have been numerous letters sent to HHS—the most recent in October—requesting greater clarity regarding compliance and enforcement and to release final regulations regarding Medicaid parity.

Please describe how the Wellstone mental health parity legislation and the improvements added to the Affordable Care Act have improved access to mental health services.

Answer 1. The Affordable Care Act (ACA) and the regulations implementing the ACA included numerous provisions relevant to behavioral health, including increases in health coverage through the Health Insurance Marketplaces and Medicaid expansion; application of mental health parity to qualified health plans issued by the Marketplaces and other individual and small group health plans; and a requirement that young adults (under age 26) be allowed to remain on their parent or guardian's health plan.

Under the Affordable Care Act, most individual and small-group health plans (including Qualified Health Plans), must provide essential health benefits, including mental health and substance use disorder treatment. The final rule implementing these provisions requires mental health and substance use disorder services, including behavioral health treatment, required to be covered as essential health benefits are subject to parity requirements laid out in the Mental Health Parity and Addiction Equity Act (MHPAEA).

As a result of the ACA and MHPAEA, HHS projected in a 2013 report that 32 million Americans will gain new health coverage that includes coverage of mental and substance use disorders and an additional 30 million people who already had insurance will benefit from parity protections that prevent restrictions on behavioral health benefits that are not also applied to physical health benefits.

Question 2. My colleagues and I have sent a letter to HHS asking that the agency investigate the findings reported in the recent NAMI study.

Has this investigation begun? If the investigation has not yet begun, what has caused the delay? If the investigation has begun, are you uncovering similar discrepancies between mental health and physical health coverage when it comes to access?

Answer 2. SAMHSA remains committed to working with HHS to provide consumers access to mental health and substance-use disorder benefits. In the May 8, 2015 letter sent to Secretary Burwell by 17 Senators, HHS was asked to proactively take steps to ensure that qualified health plan issuers on the Federal Marketplace make public an accurate, up-to-date list of mental health providers participating in-network; ensure that mental health and substance use disorder benefits are clearly enumerated in the summary of benefits; and require an explanation of benefits that includes the criteria for making medical necessity determinations on such coverage.

In the *HHS Notice of Benefit and Payment Parameters for 2016* final rule, HHS required qualified health plan issuers to publish an up-to-date, searchable, and complete provider directory, including the requested information on which providers are accepting new patients. In addition, the rule requires issuers to make available online, and accessible to those shopping but not enrolled for coverage, detailed information about specific benefits contained the mandatory Summary of Benefits and Coverage (SBC) and any limitations or exclusions that apply. This will allow shoppers to see a comprehensive, detailed list of mental health and substance use disorder benefits before making a coverage purchase.

Finally, the November 13, 2013 final rule implementing the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, plan administrators must make available the criteria for medical necessity determinations to any current or potential plan participant or contracting provider on request. Further, the reason for any such coverage denial must also be made available to the beneficiary under the 2013 final rule.

HHS is working with other Federal departments to fully implement parity and access to mental health and substance use disorder benefits as provided under the Affordable Care Act and the Mental Health Parity and Equity Act, and SAMHSA will continue to help identify and overcome barriers to doing so.

Question 3. What additional steps can HHS and/or Congress take in order to alleviate disparities in access to care?

Answer 3. In order to alleviate disparities in access to behavioral health care, it is important to support early intervention to address serious mental illness and psychosis, develop better systems to respond to people in crisis and continue to build the behavioral health workforce.

SUPPORTING EARLY INTERVENTION TO ADDRESS SERIOUS MENTAL ILLNESS AND PSYCHOSIS

Research has shown that treatment is most effective for people if they receive it as soon as possible after psychotic symptoms begin.

The RAISE (Recovery After an Initial Schizophrenia Episode) Project funded by the National Institute of Mental Health has demonstrated improved outcomes compared with typical care in quality of life, symptoms and occupational and social functioning. Recent publications by RAISE investigators have shown that CSC is also cost-effective and can be implemented in community treatment settings nationwide (PMIDs: 26834024 and 26481174). The use of coordinated specialty care offers clients personalized treatment planning, recovery-oriented therapy, low doses of antipsychotic medications, family education and support, case management, and employment or education support soon after experiencing first episode psychosis.

This type of approach is being advanced across the country through a set-aside from SAMHSA's Mental Health Block Grant. SAMHSA is working with our Federal partners and States to advance this exciting approach across the country. Congress increased funds for this program in the fiscal year 2016 appropriations bill and SAMHSA appreciates continued engagement on this important approach.

DEVELOPING BETTER SYSTEMS TO RESPOND TO PEOPLE IN CRISIS

People having a psychiatric emergency may seek help in hospitals, they may be taken to the emergency rooms by first responders, or they may become involved in the criminal justice system. These settings often lack the time and staff with specialized training needed to address patients' needs.

SAMHSA supports intervening earlier through crisis support services designed to stabilize individuals in psychological distress and engage them in the most appropriate course of treatment. In contrast to inpatient or hospital-based care, these services are designed to reach people in their own communities. The continuum of services includes telephone hotlines, peer crisis services, crisis intervention teams, mobile crisis services, crisis stabilization beds, short-term residential services, and more. In communities with robust crisis services, individuals experiencing mental health crises will be less likely to have unnecessary law enforcement contact. When they do, criminal justice entities will be better positioned to divert individuals in crisis from the criminal justice system to community-based providers.

To support these types of services, SAMHSA proposed a crisis systems demonstration program in the fiscal year 2016 budget. Support for this program would help mitigate the demand for inpatient beds for those with serious mental illnesses and substance use disorders by coordinating effective crisis response with ongoing outpatient services and supports. These new funds would provide demonstration grants to States and communities to build, fund and sustain crisis systems capable of preventing and de-escalating behavioral health crises as well as connecting individuals and families with needed post-crisis services.

CONTINUE TO BUILD THE BEHAVIORAL HEALTH WORKFORCE

In order to take advantage of coverage expansions resulting from the ACA and MHPAEA and connect additional people in need to treatment, there must be available system capacity. Strengthening the behavioral health workforce is central to building this capacity.

There are a number of ways that the behavioral health workforce could evolve in the coming years to meet the behavioral health needs of Americans. By drawing on the experience of peer providers, we can engage individuals in treatment and ensure that they receive care that responds to their needs. In addition, as we move to a more integrated health system, it will be important to build behavioral health capacity into primary care settings and to develop team-based care which includes behavioral health expertise, so that health care systems can meet the range of physical and behavioral health care needs experienced by individuals in their care in a coordinated fashion.

SAMHSA works closely with CMS and HRSA to expand the utilization of services by behavioral health professionals, including peer support specialists, through training grants, innovation grants, and work with States. Through the Behavioral Health Workforce Education and Training grants, professionals and paraprofessionals are being trained and introduced to the behavioral and physical health fields. As part of the President's "Now is the Time" initiative, funding for the SAMHSA Minority Fellowship program doubled and was expanded to reach addiction counselors.

Question 4a. The United States has 5 percent of the world's population, but has 25 percent of the world's prison population. This is in part because mental illness

has been criminalized and the criminal justice system has become a substitute for a fully functioning mental health system.

Please specify how the Substance Abuse and Mental Health Services Administration and the Department of Justice working together to address this problem?

Answer 4a. In fiscal year 2002, SAMHSA and the U.S. Department of Justice Bureau of Justice Assistance (USDOJ/BJA) began working together to address the problem with people with mental illness who come into contact with the justice system. In that year, SAMHSA issued SM–02–010 ("Targeted Capacity Expansion Grants for Jail Diversion"), authorized by the Public Health Service Act, section 520G. SAMHSA funded 34 TCE grants that operated between 2002 and 2011.

The initiative was coordinated with BJA's "Mental Health Court Grant Program," authorized under PL 106–515, Part V, Section 2201. Congress appropriated, over a 4-year period approximately $7.5 million to the Department of Justice to administer the Mental Health Courts Program. Through this work, the two agencies established a strong and extensive foundation. For example, the agencies jointly coordinated and convened four national training and technical assistance events, sponsored jointly by BJA and SAMHSA, over the course of which thousands of criminal justice and mental health professionals learned about promising practices and emerging trends across the field.

The collaboration between SAMHSA and USDOJ/BJA was described as follows:

> "It is the intention of both agencies to collaborate on both the implementation and analysis of these two programs. The overall goal of this collaboration is to improve policy and practice for addressing the needs of persons with a mental illness or co-occurring disorder who become involved with the criminal justice system.
>
> "To this end, each agency will fund programs that do not overlap by type of diversion model implemented. SAMHSA will fund diversion programs for pre- and post-booking diversion that do not involve continuous judicial supervision for treatment and case disposition. In contrast, the Department of Justice will fund Mental Health Courts that will be limited to models where continuous judicial supervision is a key design component." (quoted in SM–02–010, p.3)

Beginning in 2002, as a result of the partnership between SAMHSA and BJA, the technical assistance providers for the TCE grants and the Mental Health Court grants launched joint quarterly meetings to ensure collaboration across initiatives in order to improve community-based responses to people with mental illness in the justice system. SAMHSA's GAINS Center and the Council of State Governments Justice Center have met quarterly since 2002. The quarterly meetings have continued for 13 years.

In fiscal year 2006, as a result of the initial appropriations for the Mentally Ill Offender Treatment and Crime Reduction Act of 2004 (MIOTCRA) (PL 108–414), a memorandum of understanding was signed by SAMHSA, BJA, the National Institute of Corrections (NIC), and the Office of Juvenile Justice and Delinquency Prevention (OJJDP). The Federal Partners meetings have met two to three times per year since 2006, with attendance by SAMHSA's GAINS Center and the Council of State Governments Justice Center. Since the passage of the Affordable Care Act, the membership of the Federal Partners has expanded to include the U.S. Department of Health and Human Services and the Centers for Medicare and Medicaid Services.

SAMHSA participates in the BJA Justice and Mental Health Collaboration Program (JMHCP) and Second Chance Act (SCA) sponsored conferences. In addition to providing grant funding directly to States, tribes and units of local government the Justice and Mental Health Collaboration Program provides for delivery of training and technical assistance to grant recipients, calls for fostering collaboration between State and local governments, and provides that the U.S. Attorney General establish an interagency taskforce to facilitate local collaborative initiatives for people with mental illness in the justice system.

The Judges' Criminal Justice/Mental Health Leadership Initiative was a joint initiative of SAMHSA and BJA from 2004–12. The Judges' Leadership Initiative was formed to help judges expand their role in community and State responses to the involvement of people with serious mental illnesses in the justice system. The JLI facilitated information sharing and networking opportunities among judges. The JLI was chaired by Judge Stephen Leifman of the 11th Judicial Circuit in Miami (FL) and Justice Evelyn Lundberg Stratton of the Ohio Supreme Court. Justice Kathryn Zenoff of the Appellate Court for the Second District of Illinois served as co-chair following Justice Stratton's departure. The JLI convened four national meetings (2004, 2006, 2008, and 2010) and developed three judges' guides: Judges' Guide to Mental Health Jargon; Judges' Guide to Mental Health Diversion; and the Judges' Guide to Juvenile Mental Jargon.

Since 2010 SAMHSA and BJA have issued joint adult drug court solicitations. Eligible drug court models include adult drug courts, Tribal Healing to Wellness Courts, DWI/DUI courts, and co-occurring courts. 89 grants have been awarded through the initiative.

a. 2015 (BJA–2015–4179): *https://www.bja.gov/Funding/15BJASAMHSADrugCourtSol.pdf*.
b. 2014 (BJA–2014–3842): *https://www.bja.gov/Funding/14BJASAMHSADrugCourtSol.pdf*.
c. 2013 (BJA–2013–3606): *https://www.bja.gov/Funding/13BJASAMHSADrugCourtSol.pdf*.
d. 2012 (BJA–2012–3261): *https://www.bja.gov/Funding/12BJASAMHSADrugCourtSol.pdf*.
e. 2011 (TI–11–001): Solicitation not available.
f. 2010 (TI–10–013): Solicitation not available.

Question 4b. What has the administration learned from these collaborations regarding how to best help individuals with mental illness when they encounter the criminal justice system?

Answer 4b. SAMHSA recommends reducing involvement with the justice system for individuals with mental illness through front-end strategies along the Sequential Intercept Model.

• Law enforcement officers are often the first responders to behavioral health crises because they are the only resource available in many communities. Over the past two decades, law enforcement agencies have sought specialized interventions, such as Crisis Intervention Teams, to improve their responses to people experiencing behavioral health crises and to reduce officer injury and use of force. CIT was developed by the Memphis Police Department (TN). The first jail diversion funding, the SAMHSA KDA initiative in the 1990s, included Memphis CIT as a grantee. SAMHSA continued to fund CIT programs in Dubuque (IA), Jackson County (MO), Bexar County (TX), and Miami (FL), among others, through the Targeted Capacity Expansion initiative.

• However, the primary mandate of law enforcement is to protect public safety. Yet specialized behavioral health responses to people in crisis (e.g., mobile crisis teams) are often under-resourced and lack 24/7 coverage. Given that law enforcement officers will continue to be called upon, even in communities with treatment options available for behavioral health crises, several communities have launched early diversion initiatives where behavioral health practitioners take over for law enforcement officers during the encounter. SAMHSA has funded the Law Enforcement and Behavioral Health Partnerships for Early Diversion in three communities since 2013.

Jail diversion programs should address public health and public safety goals.

• People with mental disorders in the justice system often have multiple and complex needs, including substance use disorders, chronic physical health conditions, chronic homelessness, histories of physical and sexual trauma, and unemployment. SAMHSA has emphasized the need for people with mental and substance use disorders in the justice system to have access to evidence-based practices, wraparound support services, and access to health coverage.

• The evaluation of the TCE programs found that the risk factors for new arrests (male participants, younger age, and prior arrests) among participants were consistent with risk factors for offender populations in general (e.g., Andrew, Bonta, & Wormith, 2006). Subsequent SAMHSA-funded initiatives, such as the Adult Treatment Court Collaboratives and the Behavioral Health Treatment Court Collaboratives, have emphasized the need for cognitive-behavioral therapies and other services that directly address risk factors for criminal behavior.

Given the prevalence of co-occurring disorders, jail diversion programs should focus on addressing mental and substance use disorders rather than mental disorders alone.

• A significant number of people in the justice system have co-occurring mental and substance use disorders. For example, over 70 percent of people in the justice system have substance use disorders and approximately 17–34 percent have serious mental illnesses—rates that greatly exceed those found in the general population (Baillargeon, et al., 2010; Ditton, 1999; Lurigio, 2011; Abram & Teplin, 1991; Abram, Teplin, & McClelland, 2003; Peters, Kremling, Bekman, & Caudy, 2012; Steadman, Osher, Robbins, Case, & Samuels, 2009; Steadman, et al., 2013). Three-quarters of people with mental disorders in jails have a co-occurring substance use disorder (Teplin, Abram, & McClelland, 1996). These individuals often require spe-

cialized interventions to address their CODs and supervision that is structured based on their needs.

Treatment courts can be effective in addressing co-occurring disorders by adopting an integrative, collaborative approach.

• In the United States, there are approximately 1,500 adult drug courts (National Institute of Justice, 2015) and 350 adult mental health courts (Goodale, Callahan, & Steadman, 2013). In 2011, SAMHSA launched the Adult Treatment Court Collaborative, which focused on bridging the treatment court cultures of drug courts and mental health courts given the prevalence of co-occurring disorders among people in the justice system. The cross-site evaluation of the first cohort of 11 grantees found that collaborative courts expanded access to services, expanded target populations, implemented infrastructure change, and consolidated activities across courts (e.g., standardized screening and assessment)..

• The Adult Treatment Court Collaborative experience resulted in guidance from the National Drug Court Institute and SAMHSA's GAINS Center (2013) on the adaptation of drug courts to better address people with co-occurring disorders. The suggested adaptations were as follows:

- Know who your participants are and what they need;
- Adapt your court structure;
- Expand your treatment options;
- Target your case management and community supervision;
- Expand mechanisms for collaboration; and,
- Educate your team.

Question 5. SAMHSA's 2011 publication—"Current Statistics on the Prevalence and Characteristics of People Experiencing Homelessness in the United States," reports that up to 26 percent of all sheltered persons who were homeless had a severe mental illness and 35 percent of all sheltered adults who were homeless had chronic substance use issues. The emotional stress and physical impact from living without shelter predisposes these individuals to physical disease.

This is a vicious cycle—mental illness contributes to homelessness and homelessness contributes to physical disease. Failing to address housing insecurity is limiting our ability to effectively treat mental illness and substance abuse. It is important to ensure that housing services and mental health treatment are provided concurrently in order to break this cycle. Permanent supportive housing is an evidence-based practice that facilitates recovery and housing security for individuals with serious mental illness.

How is SAMHSA coordinating with HUD to examine the link between housing insecurity and mental illness? What best practices have been identified? What more is needed from the public and private sectors to ensure that individuals with mental illness have access to secure housing?

Answer 5. According to the most recent Continuum of Care data published by HUD, approximately 15 percent of people who were sheltered had serious mental illnesses, and approximately 15 percent had chronic substance use disorders.[1] (These figures include an undetermined number who have both conditions.)

Overall, the number of unsheltered people declined by over 82,000 (nearly 32 percent) between 2007 and 2014, according to HUD's most recent *Annual Homeless Assessment Report to Congress* (AHAR),[2] but the number of sheltered people rose 2.5 percent in the same timeframe.

Furthermore, significant numbers of people with behavioral health conditions who might otherwise remain in shelters, in transitional housing, or on the street are living in permanent supportive housing (PSH), which is not time-limited and which offers voluntary supportive services. The number of PSH beds in the United States increased by 59 percent between 2007 and 2014, from 188,636 to 300,282. Approximately 34 percent of adults living in PSH have mental illnesses, and 10 percent have substance use disorders.

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[1] U.S. Department of Housing and Urban Development. (Oct. 17, 2015). HUD 2015 *Continuum of Care Homeless Assistance Programs Homeless Populations and Subpopulations*. Retrieved from: *https://www.hudexchange.info/resource/reportmanagement/published/CoC__PopSub__NatlTerrDC__2015.pdf*.

[2] Solari, C. D., Althoff, S., Bishop, K., Epstein, Z., Morris, S., & Shivji, A. (Nov. 2015). The 2014 Annual Homeless Assessment Report to Congress, Part 2: Estimates of Homelessness in the United States.

COORDINATION WITH HUD

SAMHSA and HUD collaborate on numerous projects, and both agencies participate in the activities of the U.S. Interagency Council on Homelessness (USICH). Together, SAMHSA and USICH promote a PSH for people with mental and substance use disorders.[3] Rather than requiring people demonstrate "readiness" for housing, providers are encouraged to place the most vulnerable people, including those with chronic physical and behavioral health conditions, into permanent housing as quickly as possible and provide flexible wrap around services in order to promote recovery and stability in housing.

HUD is an essential partner in SAMHSA's homelessness activities, and local Continuums of Care (which administer HUD homelessness funding) and Public Housing Agencies (PHAs, which administer HUD public housing and housing choice voucher funds) are involved in the implementation of SAMHSA grants. For example:

• HUD staff routinely provide technical assistance to SAMHSA grantees through SAMHSA's Homeless and Housing Resource Network (HHRN). HUD staff are involved in online learning communities for SAMHSA grantees; they are involved in planning virtual workshops; and they present at workshops and webinars. Further, SAMHSA makes its HHRN technical assistance available to HUD grantees, promoting events through HUD's email lists.

• HUD staff participated in SAMHSA's Policy Academies to Reduce the Prevalence of Chronic Homelessness, which operate at the State level to coordinate housing and services for people who have disabilities and who have experienced prolonged or repeated periods of homelessness.

• By the end of fiscal year 2016, all of SAMHSA's Projects for Assistance in Transition from Homelessness (PATH) grantees are expected to report data using the Homeless Management Information System (HMIS) designated by the local Continuum of Care. This expectation helps to streamline data gathering and analysis and ensure that a Continuum's plan to prevent and end homelessness provides appropriate services for individuals who have a serious mental illness. In addition, the PATH program's participation in HMIS allows for enhanced service coordination between SAMHSA-funded homeless outreach services and the housing and services provided by HUD-funded Continuum of Care programs.

• SAMHSA is committed to coordinated entry and actively supports HUD's policies and goals for developing these processes. Coordinated entry systems ensure that services and housing are prioritized for those who are most vulnerable, including those with behavioral health conditions. SAMHSA encourages its grantees to participate in their local coordinated entry systems in order to better integrate SAMHSA- and HUD-funded programs and to improve coordination of care. Joint technical assistance opportunities have highlighted the importance of SAMHSA grantee participation in coordinated entry systems, and additional technical assistance in this area is expected as these systems are developed and improved.

• SAMHSA's Cooperative Agreements to Benefit Homeless Individuals for States (CABHI–States) program requires grantee States to form or enhance interagency councils on homelessness that include PHAs.

IDENTIFICATION OF BEST PRACTICES

SAMHSA strongly promotes PSH, which is an evidence-based practice. SAMHSA grants enable recipients to provide voluntary, flexible services to people residing in HUD-funded permanent housing. Grant applicants are required to describe the housing in which people reside, in order to ensure that best practices are followed.

In order to promote best practices in PSH, SAMHSA offers a comprehensive toolkit[4] for implementing PSH. In addition to practical advice for mental health agencies, housing providers, and service staff, the toolkit contains research on the effectiveness of the practice for ending homelessness, as well as a tool for programs to evaluate how well they are adhering to best practice standards. The toolkit contains extensive advice for collaboration among mental health agencies, PHAs, Continuums of Care, and housing providers. A revised and expanded version of the toolkit, containing recent research, is forthcoming.

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[3] USICH and SAMHSA. (June 2014). Implementing Housing First in Permanent Supportive Housing. Retrieved from: *https://www.usich.gov/resources/uploads/asset_library/Implementing_Housing_First_in_Permanent_Supportive_Housing.pdf*.

[4] SAMHSA. (July 2010). Permanent Supportive Housing Evidence-Based Practices (EBP) KIT. Publication no. SMA10-4510. Retrieved from: *http://store.samhsa.gov/product/Permanent-Supportive-Housing-Evidence-Based-Practices-EBP-KIT/SMA10-4510*.

PUBLIC AND PRIVATE SECTOR SUPPORT

Opening Doors: Federal Strategic Plan to Prevent and End Homelessness provides a roadmap for the efforts that are needed in the public and private sector to ensure that people with behavioral health conditions have access to appropriate housing. SAMHSA, HUD, and numerous other Federal agencies have supported USICH in developing and implementing this plan. Among the key recommendations, which SAMHSA fully supports, are:

- *Get States and localities to update and implement plans to end homelessness*, which SAMHSA is promoting through its CABHI-States and PATH grants.
- *Coordinate Federal technical assistance resources related to preventing and ending homelessness*, which SAMHSA is doing by collaborating with HUD and other Federal agencies in its HHRN technical assistance.
- *Make information more readily available on working effectively with special populations*, which SAMHSA is doing by expanding technical assistance regarding homelessness among veterans, LGBT youth, older adults, and other vulnerable populations.
- *Continue to increase use of HMIS by local communities and encourage its use by additional programs targeted at homelessness*, which SAMHSA is doing by setting an expectation that PATH grantees report data through HMIS by the end of fiscal year 2016.
- *Improve access to federally funded housing assistance by eliminating administrative barriers and encouraging prioritization of people experiencing or most at risk of homelessness.* Although SAMHSA does not fund housing, its grantees work with local PHAs and Continuums of Care to prioritize the use of HUD resources for people with behavioral health conditions who are experiencing homelessness.
- *Increase service-enriched housing by co-locating or connecting services with affordable housing.* SAMHSA's PSH toolkit provides practical advice for achieving this aim.
- *Increase use of mainstream resources to cover and finance services in permanent supportive housing.* SAMHSA's SSI/SSDI Outreach, Access, and Recovery Technical Assistance (SOAR TA) Center helps connect people experiencing homelessness to Social Security benefits, with much higher success rates and in a quicker timeframe, compared to typical Social Security applications.
- *Coordinate employment services with housing and homelessness assistance.* Homelessness is the result of the inability to afford housing, and employment provides a path out of poverty. SAMHSA's Supported Employment evidence-based practice toolkit[5] provides detailed guidance on improving employment outcomes among people with behavioral health conditions, including those who are experiencing homelessness.
- *Increase the number of problem solving courts*, which SAMHSA is doing by providing grants that divert people with behavioral health conditions out of jail and into treatment programs.

Finally, a key recommendation contained in *Opening Doors* that requires concerted Federal and stakeholder action is: *Bring the supply of permanent supportive housing to scale, in partnership with State and local governments and the private sector.* Although communities have made tremendous strides in reducing homelessness, particularly among veterans and people experiencing chronic homelessness, hundreds of thousands of people continue to experience homelessness due to the lack of affordable housing. Currently, SAMHSA is partnering with USICH, HUD, CMS and several national organizations to provide up to eight States with targeted program support aimed at strengthening State-level collaboration between health and housing agencies to bring to scale permanent supportive housing by coordinating housing resources with *Medicaid-covered housing-related services*. The partnership is committed to bringing to scale the cost-effective, evidence-based solution known as permanent supportive housing to *end chronic homelessness in 2017*, as well as to support *community integration* for people with long-term services and supports needs. USICH, HHS, and HUD recognize that access to affordable, stable housing and access to coordinated and comprehensive health care services will improve health outcomes for Medicaid beneficiaries and lower health care and other public services costs for States and communities.

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[5] SAMHSA. (February 2010). Supported Employment Evidence-Based Practices (EBP) KIT. Publication no. SMA08-4365. Retrieved from: *http://store.samhsa.gov/product/Supported-Employment-Evidence-Based-Practices-EBP-KIT/SMA08-4365*.

SENATOR WHITEHOUSE

Question 1. Along with a bipartisan group of Senators including Senators Portman, Klobuchar, and Ayotte, I introduced a bill earlier this year called the Comprehensive Addiction and Recovery Act (S. 524). The bill authorizes a series of grants to States and other eligible entities to promote an integrated approach—including prevention, treatment, law enforcement tools, and recovery support—to the substance abuse epidemic we are facing across the Nation. Among other things, the bill tries to increase screening for, and treatment of, co-occurring mental health and substance use disorders in the juvenile and criminal justice systems and elsewhere.

Does your organization support the objectives set forth in S. 524?

Answer 1. SAMHSA envisions a Nation that acts on the knowledge that:

- Behavioral health is essential to health;
- Prevention works;
- Treatment is effective; and
- People recover.

In line with this vision, SAMHSA's strategic plan, *Leading Change 2.0*, includes six strategic initiatives:

- Prevention of Substance Abuse and Mental Illness;
- Health Care and Health Systems Integration;
- Trauma and Justice;
- Recovery Support;
- Health Information Technology; and
- Workforce Development.

As a result, SAMHSA works every day to expand prevention and educational efforts; identify and treat justice involved individuals with or at risk for substance use disorders by collaborating with criminal justice stakeholders and by ensuring access to evidence-based treatment; provide training and technical assistance related to evidence-based substance use disorder treatment and interventions; and work with States, communities and partners to strengthen prescription drug monitoring programs and help at-risk individuals access services.

In particular, as a public health agency, SAMHSA has a key role in advancing the Secretary's Opioid Initiative. Beyond, HHS, SAMHSA works with the Department of Justice and the Office of National Drug Control Policy (ONDCP) to implement ONDCP's four-part Prescription Drug Abuse Prevention Plan and participates in ONDCP's Interagency Workgroup on Prescription Drug Abuse to ensure coordination across the Federal Government.

A number of SAMHSA's programs support the Secretary's initiative to expand the use of medication-assisted treatment (MAT). In 2015, SAMHSA provided approximately $1 million per year for 3 years to 11 States through the "Medication-Assisted Treatment for Prescription Drug and Opioid Addiction" (MAT–PDOA) grant program which allows States to expand or enhance MAT and other clinically appropriate services for persons with opioid use disorders. In fiscal year 2016, SAMHSA proposes to increase the program by $13 million.

Additionally, the fiscal year 2016 Budget for SAMHSA includes $12 million for a new program entitled Grants to Prevent Prescription Drug/Opioid Overdose-Related Deaths which will provide grants to States to purchase naloxone, equip first responders in high-risk communities, and provide education and the necessary materials to assemble overdose kits, as well as cover expenses incurred from dissemination efforts.

The fiscal year 2016 Budget for SAMHSA also includes $10 million for a new program Strategic Prevention Framework Rx. In fiscal year 2016, SAMHSA is implementing this prevention program, targeted specifically at prescription drug misuse, to raise awareness about the dangers of sharing medications and to work with pharmaceutical and medical communities on the risks of overprescribing to young adults. SAMHSA's program will also focus on raising community awareness and bringing prescription drug use prevention activities and education to schools, communities, parents, prescribers, and their patients. SAMHSA will also track reductions in opioid overdoses and the incorporation of Prescription Drug Monitoring Program (PDMP) data into needs assessments and strategic plans as indicators of program success. SAMHSA plans to award up to 29 grants.

Thus, across the spectrum SAMHSA strongly supports, and is highly engaged in programs related to substance use prevention, treatment, and recovery support.

Question 2. Can you tell me what your agencies are doing to address the overlap between substance abuse and mental health issues and what additional tools you might like to see at your disposal?

Answer 2. Several current SAMHSA programs promote the integration of substance abuse and mental health in prevention programs, treatment, and recovery supports.

Addressing co-occurring mental and substance use disorders involved in, and at risk for involvement in, the criminal justice system is crucial. Current SAMHSA criminal and juvenile justice programs require grantees to address substance use and co-occurring mental health condition in their initiatives. Additionally, comprehensive, community-based crisis systems prevent justice involvement by diverting individuals in a mental health or substance use crisis to treatment rather than jail. SAMHSA has proposed a demonstration program, Crisis Systems: Increasing Crisis Access Response, which would require participating States and communities to develop crisis systems to address both the mental health and addiction needs of community members.

Tribal Behavioral Health Grants also promote integration for AI/AN communities that are at an elevated risk of both mental and substance use disorders.

SAMHSA also funds the Primary Behavioral Health Care Integration grant program and co-funds with HRSA the Center for Integrated Health Solutions (CIHS). CIHS promotes the development of integrated primary and behavioral health services to better address the needs of individuals with mental health and substance use conditions, whether seen in specialty behavioral health or primary care provider settings.

Other SAMHSA programs that require an integrated approach to mental and substance use disorder treatment and recovery include the Certified Community Behavioral Health Centers planning grants, and the Minority AIDS initiative. SAMHSA's prevention programs address the shared risk factors for mental and substance use disorders, including Project AWARE (Advancing Wellness and Resilience Education) and Project LAUNCH (Linking Actions for Unmet Needs in Children's Health).

Unfortunately, significant barriers to the integration of mental and substance use disorder prevention, treatment, and recovery exist. For example, most behavioral health providers are not eligible for the Medicare and Medicaid EHR Incentive Programs, so they have not received incentives to adopt electronic health records. Adoption of electronic health records helps behavioral health providers furnish appropriate, comprehensive care that links mental health treatment, substance use treatment, primary care, and treatment for other chronic conditions.

SENATOR WARREN

Question 1. According to the Health Resources and Services Administration, one in eight women suffer from postpartum depression. In Massachusetts, the Department of Mental Health has funded the Massachusetts Child Psychiatry Access Project (MCPAP) for Moms—the first statewide program dedicated to helping medical providers recognize the signs of and address the symptoms of postpartum depression in the country. The Commonwealth's Medicaid program, MassHealth, recently announced that, starting next year, it would cover the cost of post-partum depression screening for all women who give birth.

What steps has each of your agencies taken to expand programs, like the one in Massachusetts, to women across the country or otherwise address postpartum conditions?

Answer 1. SAMHSA understands how critical it is to screen, assess, refer, treat, and support mothers with or at risk for post-partum depression. It is not only beneficial to the mother, but to the child and the entire family structure. SAMHSA has a long history of providing States, tribal nations, and communities with funds and supports to not only implement parental depression screenings and referral mechanisms, but to also support the integration of behavioral health into primary care, and mental health consultation into early care and education (ECE) settings. Both the integration efforts as well as availability of mental health consultation in ECE settings allow for additional opportunities to address the mental health and social/emotional health of parents and children that are being served. Since 2008, 55 5-year Project LAUNCH (Linking Actions for Unmet Needs in Children's Health) grants have been awarded, including one to Massachusetts in 2009. Over the 5-year grant cycle, Project LAUNCH States, tribes, and communities increase the quality and availability of evidence-based programs for children and families, improve collaboration among child-serving organizations, and integrate physical and behavioral health services and supports. Lessons learned from communities guide systems changes and policy improvements at the State, territorial and tribal levels, such as implementing universal screening efforts and integrated data systems. Strong partnerships lead to the sustainability and replication of successful practices on a large scale and to systems improvements lasting beyond the life of the grant.

Project LAUNCH grantees are guided by Young Child Wellness Councils, which bring families and public and private partners together to improve policies, programs, and approaches to using data and funds effectively. Each Project LAUNCH community implements a core set of five prevention and promotion strategies drawn from current research:

- Screening and assessment in a range of child-serving settings (including screening, referral, and followup for parental depression);
- Integration of behavioral health into primary care (including screening, referral, and brief intervention, and followup for parental depression);
- Mental health consultation in early care and education;
- Enhanced home visiting with a focus on social and emotional well-being (including screening, referral, and followup for parental depression); and
- Family strengthening and parent skills training.

Moreover, maternal mental health is a key focus of Project LAUNCH that is interwoven in each core strategy. For example, enhanced home visits include mental health services and support in a mother's home delivered by a trained Home Visitor or a Home Visitor and Mental Health Consultant. This service helps pregnant women and new mothers to see themselves as a nurturing mother and attach to her baby. Specifically, mothers are assisted to explore not only the experiences she has had with her own mother or caregiver(s), but also her past trauma, substance/alcohol use and how these past experiences impact her relationship with her baby now and in the future. Screening for depression on a regular basis through the baby's first year of life helps mothers understand her own emotional and mental health, improve the mother and child relationship, as well as promote healthy development of the baby and the mother's self-care. Several Project LAUNCH States, such as Colorado, Iowa, Missouri, and New York use this promising practice to address maternal mental health, and the issue of maternal depression.

In addition to providing direct services, Project LAUNCH communities increase knowledge about healthy child development through public education campaigns and cross-disciplinary workforce development. Project LAUNCH grantees also work to address health disparities and this component is integrated into their work both at the service and system levels. A cornerstone of Project LAUNCH is the Federal-level partnership between SAMHSA, the Administration for Children and Families, the Health Resources and Services Administration, and the Centers for Disease Control and Prevention.

To provide successful alumni grantees with the supports to expand the LAUNCH model in their States and tribes, in fiscal year 2015, SAMHSA awarded five Project LAUNCH Expansion grants. These 5-year grants provide States and tribes the opportunity for broader dissemination of these innovative practices and policies that will lead to better outcomes for young children and families. This program builds on previous LAUNCH efforts and aims to expand best practices in early childhood wellness promotion and prevention of mental, emotional and behavioral disorders—including screening for parental depression—into new communities, thereby furthering implementation of the effective practices.

Massachusetts is one of the recipients of these grant funds. The Massachusetts LAUNCH Expansion will replicate the Mass LAUNCH model of integrating infant and early childhood mental health (IECMH) into primary care in three high-need communities. The Expansion will work with State agencies and other stakeholders on policy and fiscal reforms to develop a sustainable funding strategy for its "power team" model of a Clinician and Family Partner with lived experience.

The Expansion will build on the original Massachusetts LAUNCH State and local partnership between the lead applicant, the Massachusetts Department of Public Health (MDPH), and the Boston Public Health Commission. MDPH will lead the State policy component, while the Commission will use the model's replication toolkit to support practice transformation at three new community health center sites through training and technical assistance, a Learning Collaborative, and onsite coaching.

The goals of the Mass LAUNCH Expansion are to continue to demonstrate efficacy of the Mass LAUNCH model, further disseminate it, and sustain it, while continuing to support the development of the overall IECMH system of care in the State. The model replication will focus on two of the most successful components of Mass LAUNCH, integration of behavioral health into primary care and family strengthening and parent support. Family and community outcomes will include reducing parental stress (and parent depression, as well as reducing child social emotional risks and challenging behaviors) and increasing the number of primary care practices focusing on integrating IECMH into primary care. The Mass LAUNCH will embed a bi-lingual clinician and Family Partner "power team" in each site,

paired with a pediatric champion and a site administrator. This team supports the development of a family-centered medical home with a strong IECMH focus, including provision of a menu of family strengthening and parent support services.

The State systems outcome is financing reforms/policy change to support IECMH primary care integration, which will be supported by the State agency, community and family representatives on the Mass LAUNCH Young Children's Council. The Mass LAUNCH Expansion intends to serve at least 1,410 children, birth to 8, and their families across the three community health centers (240 in year one, and 390 each year in years 2–4). The sites serve a combined number of 19,294 children. The focus will be on young children and families facing adverse childhood experiences, such as exposure to violence, substance abuse, or homelessness. The three communities were selected due to high needs and their high percentages of immigrants/refugees and Latino children and their families who are likely to experience behavioral health disparities, with Chelsea serving 62 percent, Springfield 39 percent, and Worcester 21 percent Latino children and families.

In 2015, SAMHSA announced the launch of the Center of Excellence for Infant and Early Childhood Mental Health Consultation (IECMHC). Infant and Early Childhood Mental Health Consultation (IECMHC) is a preventive intervention that partners mental health professionals with children's caregivers. IECMHC builds the capacities of families and other providers, such as Home Visiting staff who frequently interact with parents, to understand and manage behaviors and build healthy relationships, resulting in improved social, emotional, and behavioral outcomes for young children.

In one study of a Healthy Families America home visiting program, almost 30 percent of mothers enrolled screened positive for depression, and about 70 percent reported experiencing at least one violent trauma in their lives. Furthermore, although estimated rates of depression among pregnant, postpartum, and parenting mothers range from 5 percent to 25 percent, a review of studies revealed that between 28 percent and 61 percent of mothers enrolled in home visiting programs were identified with depression (Pediatrics, 2013).

Home visiting programs have been successful in engaging and enrolling families who are at high risk for stress, depression, and substance abuse. However, many of these mothers may not be receiving mental health services because home visitors lack the knowledge and skills to identify mental health or determine how to appropriately address these problems. IECMHC involves a partnership between a professional consultant with early childhood mental health expertise and home visiting or family support programs, staff, and families. This integrated model holds the promise of promoting parent and child behavioral health by enhancing the capacity of home visitors to identify and appropriately address the unmet mental health needs of children and families. SAMHSA, in partnership with ACF and HRSA, launched this Center of Excellence to bring together best practices and innovations in this area to develop a comprehensive IECMHC toolkit that can be used in States, tribes, and communities across the Nation.

Question 2. What additional steps could your agencies take, within your existing statutory and budgetary authority, to expand screening programs or otherwise address postpartum conditions?

Answer 2. At this point, SAMHSA has taken every opportunity to maximize our existing statutory and budgetary authority—building on evaluation findings, lessons learned, and the latest research to build capacity within States, tribal nations, and communities for screening for postpartum depression.

[Whereupon, at 11:37 a.m., the hearing was adjourned.]

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