

**IMPLEMENTATION OF  
THE 21ST CENTURY CURES ACT:  
RESPONDING TO MENTAL HEALTH NEEDS**

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**HEARING**  
OF THE  
**COMMITTEE ON HEALTH, EDUCATION,  
LABOR, AND PENSIONS**  
**UNITED STATES SENATE**  
**ONE HUNDRED FIFTEENTH CONGRESS**  
FIRST SESSION  
ON  
EXAMINING IMPLEMENTATION OF THE 21ST CENTURY CURES ACT,  
FOCUSING ON RESPONDING TO MENTAL HEALTH NEEDS

DECEMBER 13, 2017

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**Wednesday, December 13, 2017**

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

The Committee met, pursuant to notice, at 10:03 a.m. in room SD-430, Dirksen Senate Office Building, Hon. Lamar Alexander, Chairman of the Committee, presiding.

Present: Senators Alexander [presiding], Cassidy, Young, Casey, Franken, Bennet, Whitehouse, Murphy, Warren, Kaine, and Hassan.

OPENING STATEMENT OF SENATOR ALEXANDER

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

This morning, we are holding a hearing entitled “The Implementation of the 21st Century Cures Act: Responding to Mental Health Needs.”

Senators Cassidy and Murphy were the leaders in this Committee on mental health reform and in the Senate, and those reforms were included in our 21st Century Cures Act.

Senator Murray is not here today, so she has asked Senator Murphy to fill in for her.

I have asked Senator Cassidy to chair most of this hearing, or at least until 11:45. I will come back and attend it, but I think it is appropriate that Senators Cassidy and Murphy chair the hearing, especially given their extensive work in the area, and their leadership in enacting the legislation last year.

After our witness testifies, Senators will have 5 minutes of questions.

Sean Lester is, by all accounts, a typical busy Nashville young adult with a full time job, who also attends college.

In June 2014, 2 days before his 25th birthday, he experienced his first schizophrenic experience. Since then, Sean has been admitted to the Vanderbilt Psychiatric Hospital five times, spending 10 weeks receiving psychiatric treatment.

Sean recently wrote me saying, “This may seem slightly depressing, but my story does not end there. The doctors and staff I encountered at the hospital and the Centerstone Clinic taught me to live productively again in society. I have been free of the hospital for a whole year now. During that time, I have taken medication,

returned to work, and even paid off a car. I am currently enrolled in Tennessee State University as a junior pursuing a degree in psychology.”

Sean is one person out of nearly 10 million in the United States with a serious mental health condition. Without this treatment, his story could have had a very different outcome.

In Tennessee, about 1 in 5 adults have a mental illness, according to the Tennessee Department of Mental Health and Substance Abuse. That is more than 1 million Tennesseans. Over 230,000 of them have what is considered a serious mental illness.

Over the past few years, this Committee has worked in a bipartisan way to update parts of the Federal mental health system including programs at the Substance Abuse and Mental Health Services Administration, which we call SAMHSA, for the first time in over a decade.

As I said at the beginning, this effort was championed by Senators Cassidy and Murphy, as well as Senator Collins and other Members of this Committee.

The reforms were part of the Mental Health Reform Act, which passed this Committee on March 16, 2016 and were included in the 21st Century Cures Act, which Majority Leader McConnell called, “The most important legislation Congress passed last year.”

Today marks the third hearing on the implementation of the Cures legislation. We hope the updates in this law will help more Americans access quality, evidence-based mental health care.

As I said when we began hearings on the Every Student Succeeds Act, a law is not worth the paper it is printed on if it is not implemented properly, and I intend to ensure that the 21st Century Cures Act is fully and properly implemented as well.

Our focus today is to hear how SAMHSA is implementing the mental health provisions in Cures. Of the 10 million Americans with a serious mental health illness—and that includes severe schizophrenia, bipolar disorder, and major depression—millions go without treatment as families struggle to find care for loved ones.

Most of the services and treatments for people with mental illness are provided by the private sector such as Vanderbilt, or through programs run by the states. The largest role in the Federal Government is the amount of money spent through Medicaid in partnership with the states.

The Federal Government also plays a role through SAMHSA which, while relatively small compared to Medicaid and the responsibility states have, is critically important to improving the availability and quality of prevention screenings, early intervention and treatment programs, and recovery services.

Tennessee received over \$80 million in SAMHSA grants last year.

Prior to our work on Cures, Federal mental health programs had not been updated in over a decade, and the coordination between Federal agencies was not as effective as it could have been. I hope today we will learn more about how implementation of those provisions is going. How has coordination improved among Federal agencies on the best way to assist those with mental illness?

For example, we hope that promising research into early intervention programs at the National Institutes of Health would translate into clinical applications for patients.

We also included updates to the SAMHSA block grants to states to ensure that funding is best meeting the needs of those suffering from mental illness.

In addition to improve the care patients receive, we encouraged the adoption of proven scientific approaches to treatment. So I would like also to hear how the agency started to incorporate more evidence-based approaches for treating mental health.

We also hope the reforms would help increase integration between primary care and mental health care, ensure that insurance coverage for mental health disorders is comparable to insurance coverage for other medical conditions, and strengthen suicide prevention efforts.

Dr. McCance-Katz, our witness today, serves as the first Assistant Secretary for Mental Health and Substance Use, a position we created in the 21st Century Cures Act.

She has new authorities through Cures to work with states and Federal agencies, and help more Americans receive the treatment they need.

I look forward to hearing about the progress being made to ensure more people can receive the help they need, and have positive outcomes like Sean.

I would now like to turn the chairing of this hearing over to Senator Cassidy. Senator Murphy will make an opening statement, then Senator Cassidy will make a statement, and then Senator Cassidy, you can take it from there.

Thank you very much.

Senator Cassidy [presiding]. Thank you.

#### OPENING STATEMENT OF SENATOR MURPHY

Senator MURPHY. Thank you very much, Chairman Alexander.

Thank you to both you and Ranking Member Murray for holding this important hearing. Thank you to Senator Murray for allowing me to sit in her place and to Senator Cassidy for years of our partnership on this issue.

It is indeed fitting that we are holding this hearing on the 1-year anniversary of President Obama signing the legislation that established this new position at the Department of Health and Human Services.

Dr. McCance-Katz is the first-ever Assistant Secretary for Mental Health and Substance Use, a position that is long overdue.

It is also almost 5 years to the day since the terrible tragedy at Sandy Hook Elementary School, when a young man, with serious mental illness, killed 20 first graders and 6 adults.

Now, let us be clear, there is no inherent connection between mental illness and violence. America has no more mental illness than any other country, and yet, we have a gun violence rate that is 20 times higher than comparable nations. But we also know that when people fall through the cracks of our fractured mental health system, it can have a devastating impact.

In the aftermath of that tragedy, Republicans and Democrats were able to come together to pass the Mental Health Reform Act,

which was part of the 21st Century Cures Act. It represents the first comprehensive overhaul and reauthorization of our Nation's mental health laws in a generation.

It was supported by the mental health community. It garnered equal support from both parties, and it could not have happened without the bipartisanship of this Committee, which is, of course, a testament to Chairman Alexander and Ranking Member Murray.

I think the legislation's most important provision is the part that built upon the Mental Health Parity and Addiction Equity Act by strengthening enforcement of that law and making it more transparent for Americans.

Still, there are two recent reports that illustrate how far we still need to go to fully achieve that vision of parity.

A couple of weeks ago, NAMI released its third nationwide parity report, which found that more than 1 out of 3 respondents with private insurance had difficulty finding a mental health therapist, compared with only 13 percent reporting difficulty finding a medical specialist.

Similarly, Milliman released a study that found that insurers pay primary care providers 20 percent more for the same types of care that they pay addiction and mental health specialists, including psychiatrists. In many states, the disparities in payment rates were two to three times greater, rates higher for medical doctors for people practicing medicine below the neck than those who are practicing medicine above the neck.

Fortunately, the 21st Century Cures Law provides additional authority to the Trump administration on parity, and I hope that we will begin to see these provisions implemented soon.

The law also created the position of the Assistant Secretary, as I mentioned. This was an important step to make sure that there was one person at the top of the leadership of the department who is solely focused on these issues. We also codified the role of the Chief Medical Officer within SAMHSA to work closely with you.

Other provisions include several grant programs to improve coordination of mental health treatment, the creation of the first-ever infant and early childhood mental health grants. There is a section of the bill that promotes workforce development.

After hearing from consumers and providers about how there was confusion around HIPAA and when it was allowable to share personal health information, we included new authorization for HHS to develop educational materials to help patients, and clinicians, and family members better understand when these disclosures can take place.

There are other elements of the bill that will likely come up today, but we have to remember that none of the programs that we authorized in this bill matter if we do not fund them.

Congress has an awful habit of talking a really good game on mental health and addiction, but then never being willing to actually meet our rhetoric with resources. The current Labor-HHS appropriations bill does not yet include funding for the new programs in the bill we passed last year.

Even worse, the health repeal bill, that Republicans tried to push through the Senate earlier this year, would have cut Medicaid



funding over time by \$800 billion. Medicaid, of course, is the Nation's primary payer for mental health treatment.

But the legislation that we passed as part of the 21st Century Cures Act is still groundbreaking. If properly funded, it will save lives.

I am deeply thankful, again, to the Committee for their work in making this bill possible and for calling this hearing.

Last, I would just like to ask unanimous consent that Ranking Member Murray's opening statement be placed in the record.

Senator CASSIDY. Without objection.

Senator MURPHY. Thank you.

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OPENING STATEMENT OF SENATOR MURRAY

Chairman Alexander, thank you. And thank you to all our colleagues for joining us this morning.

One year ago today, President Obama signed into law the 21st Century Cures Act. This was an important bipartisan step forward. Together, we took significant action to improve the lives of patients and families.

We made progress to advance life-saving medical research and innovative products; tackle some of our hardest-to-treat diseases, like cancer and Alzheimer's; and address a truly urgent health threat facing our country today: the opioid epidemic—a crisis that each year kills tens of thousands and that continues to worsen each day.

Like all my colleagues, I've heard from far too many people in my home State of Washington—of all ages and background—about the ways substance use disorders, including opioid use disorder, are ruining lives and tearing families apart. And I've heard from countless of local, state, and national health leaders about the impact addiction has had on an already overtaxed mental health system and what that means for patients suffering from serious mental illnesses.

As I've said before, these are issues that do not discriminate. They are issues that can reach anyone—and they can reach anywhere. And so I want to touch on a couple key points.

As Democrats have made clear, when it comes to combating the opioid crisis improving policy isn't enough. We need new investments and resources—and we need them as quickly as possible.

While we must do more, I am proud that Cures took an important first step and dedicated \$1 billion in new funding—above and beyond the budget caps—to help states and communities fight back against this opioid crisis. And that we secured important changes to ensure this money went directly to states critically in need.

Along with this new funding, Cures advanced important bipartisan mental health reforms. For one, we prioritized expanding access to quality care for mental illness and substance use disorders. We strengthened coordination between local and Federal agencies engaged in crisis intervention. And we invested more resources to strengthen our behavioral health workforce.

Now, these efforts are already making a real difference for so many nationwide—that much is certain. But as I have long said, a law is only as good as its implementation, and so we need strong congressional oversight of Cures to ensure its full potential is realized.

I am glad to have Dr. McCance-Katz from the Substance Abuse and Mental Health Services Administration here with us today. I'm looking forward to your updates on implementing many of the mental health and substance use disorder provisions in Cures, and I am interested in your thoughts on what more is needed.

As you know, I am very concerned with President Trump's failure to meaningfully respond to the opioid crisis. Again, what's needed to make a real difference in the lives of patients and families struggling from addiction are real, immediate resources to fight this battle on the ground. But so far, and despite their own analysis pointing to its urgent need, the Trump administration has repeatedly failed to identify any additional funding to battle the epidemic.

I want to hear more from you about that, as well your views on resources for addressing all mental health and substance use disorders; what more we can do to protect the civil rights of individuals with serious mental illness; and your thoughts on improving training for law enforcement and others to better understand individuals with substance use and mental health challenges.

I am proud of the steps we took in Cures when it comes to mental health and substance use disorders. And I believe we can say with confidence that our work is having a real impact for patients and families, and that we are moving in the right direction when it comes to the law's implementation.

One year later, I would urge all our colleagues to remain mindful that many of the public health challenges we sought to address with Cures—particularly substance abuse and misuse—are only growing more urgent. And so it is not only important that we get implementation right, but that we also keep pushing to do more in the near-and long-term.

Thank you.

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#### STATEMENT OF SENATOR CASSIDY

Senator CASSIDY. As many of you know, I am a physician who worked for 25 years in Louisiana's charity hospital system, and I learned a couple of lessons.

One, that when the patient has the power, the system lines up to serve the patient where she or he gets the need that she or he needs.

But what I have also observed is that those with serious mental illness have no power. Their ability to act upon the resources that are available is lost by the disorder which is in their mind.

Now, this is not just an experience for a fellow who has worked in a public hospital for the uninsured. It is the experience of us all, whether it is a family member, an associate, someone we went to high school with. We all know someone who seemed to have such promise and that promise was snuffed out by serious mental illness. And their ability to execute power totally lost because of that.

Now, Government has a role and Government has a role at its best to help those who are most vulnerable. There has been a tangle of efforts by Government to attempt to help those who have serious mental illness.

I was so privileged to work with Senator Murphy and others on this Committee for the Mental Health Bill of 2016. We created the position that Dr. McCance-Katz is the first to hold to create the authority to untangle this mess. To somehow take this whole mish-mash—some effective, some not, some would be effective if coordinated—of Government programs and line them up to help those with serious mental illness.

We are now about the 1-year anniversary of that bill's signing and this is a hearing to look at the effectiveness of this. And let me say, sometimes these committees are confrontative. This is about collaboration and cooperation. How do we work together with this newly created position so that we can better serve those folks who have lost their power for almost anything because of serious mental illness?

My goal is that when that 24-year-old has her first psychotic episode, it is her last psychotic episode. And when she is 50 years old, she does not look back upon that single event as a life-defining event leading up to the breakup of her marriage, loss of her children, loss of her health. But rather, she looks back upon it as a distant memory from which she grew and actually became a better person.

That is the goal of all of us. We look forward to your testimony today, Dr. McCance-Katz, as to how ultimately we restore wholeness and return power to that patient.

So thank you for being here, and now I will make your introduction.

I am very pleased to welcome Dr. Elinore McCance-Katz to today's hearing. Dr. McCance-Katz is the Assistant Secretary for Mental Health and Substance Use at the Substance Abuse and Mental Health Services Administration.

The 21st Century Cures Act created the office of Assistant Secretary for Mental Health and Substance Use, replacing the role of SAMHSA Administrator.

Dr. McCance-Katz formerly served as the Chief Medical Officer for the Rhode Island Department of Behavioral Health Care, Developmental Disabilities, and Hospitals. Before that, she served as Chief Medical Officer for SAMHSA.

Welcome, again, Dr. McCance-Katz.

You have 5 minutes to give your testimony and we shall hear from you now.

**STATEMENT OF ELINORE F. MCCANCE-KATZ, M.D., PH.D., ASSISTANT SECRETARY FOR MENTAL HEALTH AND SUBSTANCE USE, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, ROCKVILLE, MD**

Dr. MCCANCE-KATZ. Thank you so much, Senator Cassidy, Senator Murphy, and Members of the Health, Education, Labor, and Pensions Committee.

Thank you for inviting me to testify at this important hearing today.

One year ago today, the 21st Century Cures Act was signed into law, and the Substance Abuse and Mental Health Services Administration has been actively implementing its provisions in concert with our colleagues of the Department of Health and Human Services, state and local governments, tribal entities, and other key stakeholders.

For over 25 years, I have served people with serious mental illness and serious substance use disorders. It is such a privilege for me, and an honor for me to serve as the first Assistant Secretary for Mental Health and Substance Use.

As the Assistant Secretary, I take my duties seriously. The Cures Act has asked that the Assistant Secretary look at disseminating research findings and evidence-based programs to improve prevention and treatment services, ensure that grants are subject to performance and outcome evaluations, consult with stakeholders to improve mental health services for those with serious mental illness, and children with serious emotional disturbances. And we, and I, work actively on that.

Part of strengthening leadership and accountability at SAMHSA includes a strong clinical perspective at the agency.

The Cures Act codifies the role of the Chief Medical Officer and we have taken this further by expanding the office of the Chief Medical Officer to include two additional psychiatrists and a nurse practitioner.

A new component of SAMHSA created by the Cures Act is the National Mental Health and Substance Use Policy Laboratory. The Policy Lab will promote evidence-based practices and service delivery models through evaluating models that would benefit from fur-

ther development and through expanding, replicating, or scaling evidence-based practices across a wider area.

The Interdepartmental Serious Mental Illness Coordinating Committee, what we call ISMICC, was established by the Cures Act to ensure better coordination across the Federal Government to address the needs of individuals with serious mental illness and serious emotional disturbances, as well as their families.

I was pleased to chair the first meeting of the ISMICC in last August, which was attended by key leaders in Federal Government, as well as 14 highly qualified, non-Federal members. The ISMICC has been working within five key areas of focus:

Strengthening Federal coordination to improve care; Closing the gap between what works and what is offered; Reducing justice involvement and improving care for those justice-involved; Making it easier to obtain evidence-based behavioral healthcare, and; Developing finance strategies to increase availability and affordability of care.

As required by the Cures Act, the ISMICC Report will be delivered to Congress today. I just show you this. We are very pleased to bring it to Congress on time and I hope that you will be pleased with it.

The Cures Act reauthorized the Community Mental Health Services Block Grant and codified the first episode of psychosis set-aside. The set-aside is vitally important to ensuring that individuals developing SMR receive timely and appropriate treatment if we can intervene early with needed treatment in psychosocial services, people are better able to live with their illnesses similar to other chronic health conditions.

I strongly support the reauthorization in the Cures Act of Assisted Outpatient Treatment or the AOT program. In Fiscal Year 2016, SAMHSA implemented an AOT grant program and awarded 17 grants.

SAMHSA has partnered with the Assistant Secretary for Planning and evaluation to implement a cross site evaluation, which will assess the effectiveness and impact of this program.

One very important area that the Cures Act addressed was suicide prevention. In 2015, over 44,000 Americans died by suicide and there are over 1.1 million suicide attempts annually in the United States.

The Cures Act authorized SAMHSA existing National Suicide Prevention Lifeline. In 2017, the Lifeline has already answered over 1.67 million calls, surpassing by 100,000 those recorded for all of 2016, and we are not done with 2017 yet.

Suicide remains the second leading cause of death for individuals 15 to 24 years old. The Cures Act reauthorized the Garrett Lee Smith Memorial Act, which provides grants to states and tribes to reduce youth suicide and suicide attempts.

At the same time, the highest rate of suicide in America is among adults 45 to 64 years old. Prior to the Cures Act, there was no authorized suicide prevention program for adults at SAMHSA. We are grateful for the authorization of the Adult Suicide Prevention Program in Cures, and for Congress's funding of the program in Fiscal Year 2017. As a result, we have awarded grants for Zero

Suicide, which is a program that implements suicide prevention and intervention programs within health systems.

Ensuring children and adolescents at risk for, and living with, behavioral health conditions receive services and support they need was a key element of the Cures Act.

The National Child Traumatic Stress Initiative was reauthorized by the Cures Act and has provided resources to communities and individuals impacted by natural disasters and other traumatic events impacting the mental health of all Americans.

As directed by the Cures Act, SAMHSA is working collaboratively with the HHS Office of Civil Rights on guidance that will clarify permitted uses and disclosures of protected health information by healthcare professionals under HIPAA to improve communication with caregivers of adults with serious mental illness in order to facilitate treatment.

With the passage of the Cures Act, we continue to recognize the critical role of behavioral health parity in ensuring equitable, high quality health and behavioral healthcare for all Americans.

SAMHSA has conducted two Parity Policy Academies to improve parity implementation in the commercial insurance market, Medicaid, and the Children's Health Insurance Program.

The HHS Parity Website has been updated to include information from a public listening session, as has the Insurance Parity Portal, which provides information for individuals who may have experienced a parity violation.

Much work has been undertaken at SAMHSA and across HHS to implement the Cures Act, but we know this work is far from over. There are many more individuals and families struggling with mental and substance use disorders that need help.

I look forward to continuing a strong partnership with Congress to help these people and their families, and to answering your questions.

[The prepared statement of Dr. McCance-Katz follows:]

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PREPARED STATEMENT OF ELINORE F. MCCANCE-KATZ

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. One year ago today, the 21st Century Cures Act (Cures Act) was signed into law, and the Substance Abuse and Mental Health Services Administration (SAMHSA) has been actively implementing many of the provisions in coordination with our colleagues at the Department of Health and Human Services (HHS), State and local governments, tribal entities, and other key stakeholders.

The Cures Act touches on so many important issues. The Act strengthens leadership and accountability for behavioral health at the Federal level<sup>1</sup>, ensures mental health and substance use disorder prevention, treatment, and recovery programs keep pace with science and technology<sup>2</sup>, supports State prevention activities and responses to mental health and substance use disorder needs<sup>3</sup>, promotes access to mental health and substance use disorder care, and strengthens mental and substance use disorder care for children and adolescents<sup>4</sup>. We at SAMHSA appreciate your leadership and dedication in enacting new authorities to reduce the impact of substance abuse and mental illness on America's communities.

<sup>1</sup> 21st Century Cures Act, Pub. L. No. 114-255, Title VI, 130 Stat. 1033 (2016).

<sup>2</sup> Id. at Title VII.

<sup>3</sup> Id. at Title VIII.

<sup>4</sup> Id. at Title X.

In my testimony, I will highlight how SAMHSA is implementing some of the key provisions of the Cures Act and how it is benefiting the behavioral health community and, most importantly, individuals living with mental illness and/or addiction and their families.

### **Strengthening Leadership and Accountability**

I am humbled and honored to serve, thanks to the Cures Act, as the first Assistant Secretary for Mental Health and Substance Use. As the Assistant Secretary, I take seriously my duties as outlined in the Cures Act such as maintaining a system to disseminate research findings and evidence-based programs to service providers to improve prevention and treatment services; ensuring that grants are subject to performance and outcome evaluations; consulting with stakeholders to improve community-based and other mental health services including for adults with serious mental illness (SMI) and children with serious emotional disturbances (SED); collaborating with other departments (such as the Department of Veterans Affairs, Department of Defense, the Department of Housing and Urban Development (HUD), and the Department of Labor (DOL)) to improve care to veterans and service members and support programs to address chronic homelessness; and working with stakeholders to improve the recruitment and retention of mental health and substance use disorder professionals<sup>5</sup>. SAMHSA is a small agency with a small budget, but it has a very important mission. We must use our resources wisely and focus on the most pressing issues: those of SMI and the opioid crisis.

Strengthening leadership and accountability at SAMHSA includes ensuring a strong clinical perspective at the agency. The Cures Act codifies the role of the Chief Medical Officer and we have taken this further by expanding the Office of the Chief Medical Officer to include two additional psychiatrists and a nurse practitioner. The Office of the Chief Medical Officer responsibilities include:

- Serving as a liaison between SAMHSA and providers;
- Assisting the Assistant Secretary in evaluation, organization, integration, and coordination of SAMHSA programs;
- Promoting evidence-based and promising practices; and
- Coordinating internally and externally to assess the use and ensure the utilization of appropriate performance metrics.

The Office of the Chief Medical Officer is strategically positioned within SAMHSA to facilitate the development of policy, practice, and programs that comport with best practices and current trends in contemporary health care.

The Cures Act codified the Center for Behavioral Health Statistics and Quality, which serves as the Federal Government's lead agency for behavioral health statistics. The Center for Behavioral Health Statistics and Quality conducts national surveys tracking population-level behavioral health issues, and a new Office of Evaluation will be responsible for conducting SAMHSA's program evaluations. For example, the Center for Behavioral Health Statistics and Quality data collection efforts include the National Survey on Drug Use and Health and the Treatment Episode Data Set. The Center for Behavioral Health Statistics and Quality also is responsible for collecting Government Performance and Results Act data from our grantees. The Center for Behavioral Health Statistics and Quality will also be developing a standardized evaluation with specific questions related to each program that will inform us about the functioning of programs, and help us to determine whether programs are meeting stated goals in serving Americans living with behavioral health disorders and their families.

The Interdepartmental Serious Mental Illness Coordinating Committee was required by the Cures Act to ensure better coordination across the entire Federal Government related to addressing the needs of individuals with SMI and SED and their families. I was pleased to chair the first meeting of the Interdepartmental Serious Mental Illness Coordinating Committee in late August which was also attended by Secretary Carson of HUD and many other key leaders in the Federal Government as well as 14 non-Federal members. The Interdepartmental Serious Mental Illness Coordinating Committee has been working within five workgroups that focus on:

1. Strengthening Federal coordination to improve care;
2. Closing the gap between what works and what is offered;
3. Reducing justice involvement and improving care for those who are justice involved;
4. Making it easier to obtain evidence-based behavioral health; and
5. Developing finance strategies to increase availability and affordability of care.

<sup>5</sup> Id. at Sec. 6002.

Tomorrow morning, December 14, we will be holding a press event to release the first Interdepartmental Serious Mental Illness Coordinating Committee Report to Congress which will be followed by the second public meeting of the Interdepartmental Serious Mental Illness Coordinating Committee. The report includes recommendations from the non-Federal members of the Committee and sets the stage for intensive work by the Interdepartmental Serious Mental Illness Coordinating Committee in the years ahead. The meeting will focus on next steps for the Committee. HHS leadership and staff look forward to working with the other Federal departments represented on the Committee, as well as the non-Federal public members of the Committee and Congress, in order to improve Federal coordination and the systems that serve people living with SMI.

**Ensuring Mental Health and Substance Use Disorder Prevention, Treatment and Recovery Programs Keep Pace with Science and Technology<sup>6</sup>**

The Cures Act created the National Mental Health and Substance Use Policy Laboratory (Policy Lab). The Policy Lab will promote evidence based practices and service delivery models through evaluating models that would benefit from further development and expansion. In particular, the Policy Lab will focus on schizophrenia and schizoaffective disorder, as well as other SMI. It will also focus on evidence-based practices and services for addiction with focus on opioids.

The responsibilities of the Policy Lab include: to identify, coordinate, and facilitate the implementation of policy changes likely to have a significant effect on mental health and mental illness; to work with the Center for Behavioral Health Statistics and Quality to collect information from grantees under programs operated by the Administration in order to evaluate and disseminate information on evidence-based practices, including culturally and linguistically appropriate services and service delivery models; to provide leadership in identifying and coordinating policies and programs, including evidence-based programs, related to mental illness and substance use disorders<sup>7</sup>; to periodically review programs and activities operated by the Administration relating to the diagnosis or prevention of, treatment for, and recovery from, mental illness and substance use disorders, including identifying any such programs or activities that are duplicative and are not evidence-based, effective, or efficient.

**Supporting State Prevention Activities and Responses to Mental Health and Substance Use Disorder Needs<sup>8</sup>**

The Cures Act reauthorized the Community Mental Health Services Block Grant and codified the first episode psychosis set-aside. This set-aside is vitally important to ensuring that people with SMI receive appropriate treatment. If we can intervene early and provide needed treatment and psycho-social services, people are able to manage their SMI as chronic health conditions. I want to share with you one success story from the first episode psychosis program.

Jesse (whose name has been changed to protect privacy), is a 26 year old African American male. Jesse experienced his first episode of psychosis during his senior year of college. He was able to graduate, but was hospitalized shortly thereafter. Jesse's symptoms were primarily delusional in nature and centered on his beliefs that various people and influential groups were trying to surveil him, harm him, and ultimately ruin his future. This challenging combination of symptoms resulted in Jesse suffering through four hospitalizations over the course of 6 months before being referred to the first episode psychosis program. Jesse's challenges with accepting his illness and allowing treatment to proceed as recommended complicated his situation. For example, Jesse stopped taking medications frequently, particularly early in treatment.

As Jesse began to develop trust with the team of providers, he opened up to the idea of medications and other treatments. As time passed he began to increase his participation in all aspects of the program, and a significant improvement was observed. This progress was interrupted when Jesse opted to stop medications half-way through his time in the program. This discontinuation resulted in a hospitalization. Since that hospitalization Jesse has started a long acting injectable antipsychotic medication in order to improve his follow through and maintain his functioning. Jesse is now

<sup>6</sup> Id. at Title VII.

<sup>7</sup> Id. at Sec. 7001.

<sup>8</sup> Id. at Title VIII.

approaching the end of 2 years in the program and things have changed significantly for him. He recently accepted his first full time job with competitive pay and benefits.

#### **Promoting Access to Mental Health and Substance Use Disorder Care<sup>9</sup>**

The Cures Act reauthorized many critical programs at SAMHSA such as Projects for Assistance in Transition from Homelessness. The Projects for Assistance in Transition from Homelessness program funds services for people with SMI experiencing homelessness. These include outreach, screening, and referral services to get people with mental health and substance abuse issues off the streets and into housing, as well as the primary healthcare, mental health and substance abuse treatment, job training and other services to help them be successful in staying housed.

The Cures Act reauthorized the Assisted Outpatient Treatment program. Assisted outpatient treatment programs are court-supervised treatment that take place in the community, sometimes referred to as “(involuntary) outpatient commitment.” In fiscal year 2016, SAMHSA implemented an Assisted Outpatient Treatment grant program and awarded 17 grants through the program. A variety of program types are eligible for these grants, including, county and city mental health systems, mental health courts, and any other entities with authority under the law of the State in which the grantee is located to mandate Assisted Outpatient Treatment. This 4-year pilot program is intended to implement and evaluate new Assisted Outpatient Treatment programs and identify evidence-based practices in order to reduce the incidence and duration of psychiatric hospitalization, homelessness, incarcerations, and interactions with the criminal justice system, while improving the health and social outcomes of individuals with an SMI. This program is designed to work with families and courts to allow these individuals to obtain treatment while continuing to live in the community and their homes. Grants were awarded to applicants that have not previously implemented an Assisted Outpatient Treatment program. SAMHSA has partnered with the Assistant Secretary for Planning and Evaluation and the National Institute of Mental Health (NIMH), a component of the National Institutes of Health, to implement a cross-site evaluation that will assess the effectiveness and impact of the Assisted Outpatient Treatment grant program. Additional program outcomes to be evaluated will include the rates of incarceration, employment, healthcare utilization, mortality, suicide, substance use, hospitalization, homelessness, and use of services. SAMHSA continues to consult with NIMH, the Attorney General, and the Administration for Community Living on this pilot program. In addition, SAMHSA is working with families and courts in the implementation of this program.

Assertive Community Treatment is another important program for people with SMI, and SAMHSA is grateful that the Cures Act authorized a program for Assertive Community Treatment. SAMHSA’s fiscal year 2018 Budget requested \$5 million dollars for the Assertive Community Treatment program. Assertive Community Treatment is an evidence-based practice considered one of the most effective approaches to delivering services to people with SMI and has been disseminated by SAMHSA for widespread use through its Evidence-Based Toolkit series beginning in 2008. Assertive Community Treatment was developed to reduce re-hospitalization and improve outcomes on discharge. Assertive Community Treatment is designed as a coordinated care approach to provide a comprehensive array of services, including medication management and other supportive services, directly rather than through referrals. An Assertive Community Treatment team is composed of 10–12 transdisciplinary behavioral health staff—including psychiatrists, nurses, peer specialists and others—working together to deliver a mix of individualized, recovery oriented services to approximately 100 people with SMI to help them to integrate into the community. Assertive Community Treatment caseloads are approximately one staff to every 10 individuals served. The services are provided 24 hours, 7 days a week and as long as needed, wherever they are needed. Teams often find they can anticipate and avoid crises. If funded in the final appropriations bill, in fiscal year 2018 SAMHSA will award grants, to states, counties, cities, tribes and tribal organizations, mental health systems, healthcare facilities, and other clinical entities to establish, maintain or expand Assertive Community Treatment programs. Special consideration will be given to applicants that serve those adults with SMI who are high utilizers of healthcare and social services including homeless and justice involved populations. In addition, technical assistance and a program evaluation will be supported. The program evaluation will include public health outcomes inclusive of mortality, suicide, substance use, hospitalization; rates of homelessness and in-

<sup>9</sup> Id. at Title IX.



volvement with the criminal justice system; patient and family satisfaction with program participation, and; service utilization and cost.

One important area that the Cures Act addressed is suicide prevention. In 2015, 44,193 Americans died by suicide; according to National Survey on Drug Use and Health statistics, there were approximately 1,104,825 suicide attempts in the United States annually. The Cures Act authorized SAMHSA's existing National Suicide Prevention Lifeline (Lifeline). In 2017, the Lifeline has already answered 1,670,118 calls, surpassing by over 100,000 calls those recorded for 2016. The Lifeline projects that over 2 million calls will be answered by the end of the calendar year. Last month, we received the following comment on the Lifeline website:

I just wanted to message you guys to let you know that you saved my life—quite literally—and I need to thank you. I believe I looked up your number what will be 2 years ago in exactly a week. I had a plan to take my own life, and I was going to go through with it. For some reason, there was a small part of me that wanted to live, but I couldn't figure out why so I called you. For the life of me, I cannot remember the woman's name, but she was the kindest, most empathetic person I've ever had the privilege to talk to. I don't even remember what we talked about, really. I don't think it was anything important. But she reminded me that I was a living, breathing person who had thousands of opportunities ahead of me. Of course, it took me a long time after this to completely regain my dedication to life, but I'm well on my way there. I do have ups and downs, of course, but I am still moving forward every day. I am so sorry that I can't remember this woman's name, but whoever you are, thank you. And thank you all for saving my life. I'm now going to my dream school, studying things that I love, and I could not be happier.

Suicide remains the second leading cause of death for individuals 15–24 years old. The Cures Act reauthorized the Garrett Lee Smith Memorial Act, which provides grants to states and tribes to reduce youth suicide and suicide attempts. At the same time, the highest rate of suicide in America is among adults 45–64 years old. Prior to the Cures Act, there was no authorized suicide prevention program for adults at SAMHSA. SAMHSA is grateful for the authorization of the adult suicide prevention program in Cures and for Congress' funding of the program in Fiscal Year (FY) 2017. In fiscal year 2017, SAMHSA awarded three grants for the Zero Suicide program. The purpose of this program is to implement suicide prevention and intervention programs within health systems for people who are 25 years of age or older. The comprehensive, multi-setting approach will raise awareness of suicide, establish referral processes, and improve care and outcomes for individuals who are at risk for suicide. The program funds three grantees (The New York State Office of Mental Health, the Choctaw Nation of Oklahoma, and the University Health System in San Antonio, Texas) at a total cost of \$7.5 million. SAMHSA also provided five grants under the Cooperative Agreements to Implement the National Strategy for Suicide Prevention program. The purpose of this program is to support states in implementing the 2012 National Strategy for Suicide Prevention goals and objectives focused on preventing suicide and suicide attempts among adults, ages 25 and older, to reduce the overall suicide rate and number of suicides in the United States. This \$7 million program supports five grantees (University of Central Florida—supporting the Florida Implementation of the National Strategy for Suicide Prevention, Massachusetts State Department of Mental Health, Maine Department of Health and Human Services, Tennessee State Department of Mental Health and Substance Abuse Services, and the Utah Department of Human Services).

#### **Strengthening Mental and Substance Use Disorder Care for Children and Adolescents<sup>10</sup>**

Ensuring children and adolescents at risk for and living with behavioral health conditions receive the services and supports they need was a key element of the Cures Act, and SAMHSA is implementing many of these elements. Since the Cures Act passed, our Nation has faced several natural disasters and man-made traumatic events that have impacted the mental health of all Americans, but especially children and adolescents. The National Child Traumatic Stress Initiative was reauthorized by the Cures Act and has provided resources to communities and individuals impacted by these tragedies. As one example, the National Child Traumatic Stress Initiative conducted a Psychological First Aid Train the Trainer course for the State of Texas in response to Hurricane Harvey. Participants were selected from HHS-

<sup>10</sup> Id. at Title X.

contracted behavioral health providers, giving priority to those regions most impacted by Hurricane Harvey.

SAMHSA has also been working with the Health Resources and Services Administration and stakeholders to advance screening and treatment for maternal depression. In alignment with the Cures Act, SAMHSA continues to fund screening for depression in specific grant programs (e.g., Pregnant and Postpartum Women, Project Linking Actions for Unmet Needs in Children's Health (LAUNCH)), and participates in Federal interagency collaborations providing expertise regarding depression screening in federally supported family services programs (e.g., Department of Agriculture/Women, Infants and Children program; Health Resources and Services Administration /Maternal and Child Health Bureau Home Visiting Programs). SAMHSA's toolkit, "Depression in Mothers: More Than the Blues," (available in English and Spanish) has garnered widespread interest and uptake among family service providers. In August 2017, SAMHSA consulted with researchers, practitioners, consumers and family members to determine priority areas for practice and policy related to maternal depression, with a particular focus on low-income women; to identify best practices in screening, treatment, and innovative, technology-based interventions; to more broadly integrate this issue in medical settings, particularly among obstetricians/gynecologists, family practice, and pediatric medicine; and to identify gaps in training and workforce development. A guidance document is being prepared based on suggestions from this feedback.

It is estimated that over 7.4 million children and youth in the United States have a serious mental disorder. Unfortunately, only 41 percent of those in need of mental health services actually receive treatment. Created in 1992, SAMHSA's Children's Mental Health Initiative addresses this gap by supporting "systems of care" for children and youth with SED and their families, in order to increase their access to evidence-based treatment and supports. The Cures Act reauthorized the Children's Mental Health Initiative which provides grants to assist states, local governments, tribes, and territories in their efforts to deliver services and supports to meet the needs of children and youth with SED.

The Children's Mental Health Initiative supports the development, implementation, expansion, and sustainability of comprehensive, community-based services that use the systems of care approach. Systems of care is a strategic approach to the delivery of services and supports that incorporates family driven, strength-based, and culturally and linguistically competent care in order to meet the physical, intellectual, emotional, cultural, and social needs of children and youth throughout the United States. The systems of care approach helps prepare children and youth for successful transition to adulthood and assumption of adult roles and responsibilities. Services are delivered in the least restrictive environment with evidence-supported treatments and interventions. Individualized care management ensures that planned services and supports are delivered with an appropriate, effective, and youth-guided approach. This approach has demonstrated improved outcomes for children at home, at school, and in their communities. For example, Children's Mental Health Initiative grantee data show that suicide attempt rates fell over 38 percent within 12 months after children and youth accessed Children's Mental Health Initiative-related systems of care services. In addition, school suspensions/expulsions fell over 42 percent and unlawful behavior fell over 40 percent within 18 months of children and youth beginning systems of care related services and supports.

SAMHSA's fiscal year 2018 Budget requested that Congress allow SAMHSA the ability to develop and implement a services research demonstration effort as part of the Children's Mental Health Initiative based on the North American Prodrome Longitudinal Study funded by NIMH. During the prodrome phase, a disease process has begun but is not yet diagnosable or, or potentially, inevitable. The demonstration will address whether community-based intervention during this phase can prevent the further development of SED and ultimately SMI. The project will examine the extent to which evidence-based early intervention for young people at clinical high risk for psychosis can be scaled up to mitigate or delay the progression of mental illness, reduce disability, and/or maximize recovery. The new effort would be funded from a 10 percent set-aside of the base program and would focus on youth and young adults who are identified to be at clinical high risk for developing a first episode of psychosis. If funded, the grantees would focus on this population in order to support the development and implementation of evidence-based programs providing community outreach and psychosocial interventions for youth and young adults in the prodrome phase of psychotic illness.

### Other Priority Implementation Activities

As discussed in the hearing held by this Committee on October 5th regarding the Federal response to the opioid crisis, SAMHSA continues to work closely with states on their implementation of State Targeted Response (STR) grants. On October 30, 2017, notification was sent to all Governors indicating that the fiscal year 2018 funding allocation for the program will remain the same as it was in the first year of the program. On November 17, 2017, SAMHSA announced the availability of \$1 million in supplemental funding for 1 year to enhance STR activities in areas of the greatest need, as determined by the highest rates of overdose deaths in 2015 according to the Centers for Disease Control and Prevention data.

As directed by the Cures Act, SAMHSA is working collaboratively with the HHS Office for Civil Rights on guidance that will clarify existing permitted uses and disclosures of health information under the Health Insurance Portability and Accountability Act of 1996 by healthcare professionals to improve communication with caregivers of adults with SMI in order to facilitate treatment. In January 2017, SAMHSA issued a final rule related to Confidentiality of Substance Use Treatment Records and a Supplemental Notice of Proposed Rulemaking. The final rule facilitates the sharing of patient data for research purposes; increases patient choice to disclose more broadly, such as in integrated healthcare settings; updates the rule to be more compatible with electronic health records; and clarifies requirements for audits. The Supplemental Notice of Proposed Rulemaking sought public input related to the role of contractors, subcontractors, and legal representatives in the healthcare system with respect to payment and healthcare operations. Since the final rule was issued, SAMHSA has been providing technical assistance, developing a final rule related to the Supplemental Notice of Proposed Rulemaking, and working on additional guidance documents to help patients better understand their choices. In line with the Cures Act, SAMHSA will be convening relevant stakeholders early next year to determine the effect of the regulation on patient care, health outcomes and patient privacy.

With the passage of the Cures Act, specifically section 13002, Congress recognized the critical role behavioral health parity plays in ensuring equitable, high-quality health and behavioral healthcare for all Americans. Section 13002 called for the convening of a public listening session and the creation of a parity action plan for increased enforcement of behavioral health parity.

The listening session was held on July 27th, 2017. More than 15 groups provided public comment in person and a total of 40 comments were received via email or in writing. The Public Listening Session was concurrently webcast and attended in person by more than 75 individuals. All comments are available on the HHS website at, <https://www.hhs.gov/programs/topic-sites/mental-health-parity/achieving-parity/cures-act-parity-listening-session/comments/index.html> in addition to a recording of the event <https://www.youtube.com/watch?v=BcA-JS3fOj8>.

Comments were received from various stakeholder groups including insurance representatives, employers, behavioral health providers, and patients or their advocates. The most common concerns cited by commenters were the need for more guidance from Federal agencies, transparency from insurance companies as to parity analysis and coverage decisions, and enforcement of parity protections. The forthcoming Action Plan will include strategies and action steps to address these comments.

In March and April 2017, in collaboration with DOL, HHS's Center for Consumer Information & Insurance Oversight and HHS's Center for Medicaid and CHIP services, SAMHSA conducted two parity policy academies to provide technical assistance for improved parity implementation in the commercial insurance market, the Medicaid program and the Children's Health Insurance Program programs. In addition, the HHS parity website has been updated to include information from the Public Listening Session as well as the Parity Portal which provides information for individuals who may have experienced a parity violation.

### Conclusion

Much work has been undertaken at SAMHSA and across HHS to implement the Cures Act, but we know this work is far from over. There are many more people and their families struggling with mental illness and addiction that need help. I look forward to continuing a strong partnership with Congress to help these Americans. The Cures Act has served to focus attention and resources on the needs of Americans living with SMI and addiction, and their families. Congress has provided a blueprint for addressing these needs, and we at SAMHSA greatly appreciate their efforts.

Senator CASSIDY. Senator Murphy, would you like to go first?

Senator MURPHY. Thank you, Mr. Chairman.

Thank you, Dr. McCance-Katz. We are very excited that you are doing fantastic work in this position. You have a lot on your plate, but we are excited about some of the early deliverables.

I wanted to maybe first ask you to talk a little bit more about this question of integration, and you referenced it in your testimony.

But I would like you to talk a little bit more about the work that can be done at HHS and through CMS to try to bring together our behavioral health system and the rest of our healthcare system. Whether the proper ways to do that are working through state governments, whether there are new payment mechanisms that we could develop through CMS to try to marry together these systems.

It is an anachronism, the idea that we have one system of healthcare for your neck down and then you have to walk across town to find somebody that will treat the rest of your body. It is a slow progression to fix that, in part, because of the way that we fund mental health and mental health services.

So there is at least one grant program at SAMHSA that is designed to take this on, but tell me what you have been doing since you have been on the job to try to promote integration.

Dr. MCCANCE-KATZ. Yes, so thank you for that question because I think we are doing a fair amount.

We have funded programs that are bidirectional and that was through the Cures Act so that behavioral healthcare can be put into primary care settings, and primary care into behavioral health settings.

We also have a program that, again, Congress brought into being a couple of years ago and is now in the process of implementation and that is for the Certified Community Behavioral Health Centers.

These are programs that are focused on behavioral healthcare, but require that both serious mental illness treatment and substance use disorder treatment, as well as physical healthcare, can be in the same setting for individuals primarily diagnosed with mental disorders. So that is very important.

We work collaboratively with CMS. We are talking with them about what kinds of innovations they might be able to look at in terms of ongoing funding.

I will personally advocate for the continuation of CCBHC, the Certified Community Behavioral Health Center program, because even though we have an evaluation out, we know that FQHC's work very well and they work very well because they integrate care, and they pay for that care. And that is the other thing about the CCBHC's.

We have CMS that is providing the payment for services. I think that is going to be very important to establishing these kinds of Centers.

We also work collaboratively at SAMHSA with other operating divisions that provide direct care including HRSA, which is a much larger organization than we are, but we provide a lot of technical assistance and opportunities for training for their providers on behavioral health issues; same with the Indian Health Service.

I have also, since I started, had my Chief Medical Officer establish a relationship both with HRSA and the Indian Health Service to make sure that these things move forward.

Senator MURPHY. Often states regulate behavioral healthcare centers, and their primary care of federally Qualified Healthcare Centers, through different agencies.

When they try to combine, they often have some just simple regulatory hurdles, like the numbers of fire drills are different in the two different locations. So when they go onto one site, they often are being overregulated.

I hope that is something that you will help states try to overcome.

One final question on HIPAA, I mentioned it in my testimony. A lot of confusion out there in the community as to what clinicians can share with family members and with caregivers. We gave you the ability to develop some new guidance to try to make it clearer, I think, mostly to providers about when they are actually able to share information with a mom, or a dad, or a caregiver.

I know you are working with the Office of Civil Rights within HHS on guidance, but I just wanted you to give us an update on when we might be seeing that come forward. I think it would be really helpful to everybody in the community.

Dr. MCCANCE-KATZ. Yes, I can definitely comment on that.

For one thing, I think, today you will get a series of informational documents from the Office of Civil Rights that further clarify when information can be shared. We spoke about that, I spoke with them, actually, yesterday at HHS about it. So they told me that would be delivered to Congress today just as our ISMICC Report is coming to you today.

A few weeks ago, the Office of Civil Rights put out guidance to practitioners about what can be shared in emergency settings.

So one of the big sources of confusion has been when a person comes into an emergency department, for example, with an opioid overdose, can that information be shared with caregivers, with loved ones? And often, it has not been shared because, mistakenly, practitioners think this is covered by 42 CFR, the Federal confidentiality statutes related to substance abuse treatment.

This is not substance abuse treatment. This is treatment of a medical emergency and under HIPAA, we are able to share that. But also, it is also true that there are exceptions under 42 CFR.

We have had one guidance go out to practitioners about what they can share under emergency situations. That went out in November.

We are working on another document that will further clarify both HIPAA and 42 CFR in the same document. I like these to be short and easily digested by practitioners.

I can tell you, just last week, I was at a national meeting of substance abuse treatment providers and the issue of sharing information was one of their main issues. And so I am really grateful to Congress for the direction on this.

Senator MURPHY. Thank you for taking it so seriously.

Thank you.

Senator CASSIDY. Dr. McCance-Katz, I am going to ask you to be very kind of tight with your answers because I have a lot to ask you.

Let me just follow-up quickly with what Senator Murphy just asked you about. That is great that you are coming out with this HIPAA guidance.

Now, is there any plan, do you have the ability to turn this into a Continuing Medical Education credit, or a legal credit, or a nursing credit? Because I find those sorts of things can be trees fallen in the forest, but if you make it a CEU right before the end of the year, and everybody has to get their credits in, it has a little bit more bang.

Dr. MCCANCE-KATZ. Exactly.

We have a number of different types of training programs at SAMHSA. They address a wide variety of topics and the issue of sharing information.

Senator CASSIDY. But will these specifically be in continuing education credits?

Dr. MCCANCE-KATZ. Absolutely.

Senator CASSIDY. Wonderful.

Dr. MCCANCE-KATZ. So our programs offer this at no cost to providers. We have the Provider's Clinical Support System oriented toward physicians, nurse practitioners, and P.A.'s mainly. We have the Addiction Technology Transfer Center.

Senator CASSIDY. But you also have to get your continuing legal credits, I will just say that, because it is going to be the lawyer that they are calling in the middle of the night saying, "Hey, listen. Can I share information?" And if the lawyer says no, they are not going to do it.

Dr. MCCANCE-KATZ. So you are exactly right about that, and as somebody who has worked in a hospital setting, I can tell you that they can be a very big barrier to sharing information.

Senator CASSIDY. Lawyers a problem? I cannot imagine, but anyway.

Dr. MCCANCE-KATZ. But actually, our Chief Medical Officer, one of the things that she is working on is developing a network with hospitals and the National Hospital Associations to exactly address these kinds of issues.

Senator CASSIDY. Okay. Let me, then, go on.

In our legislation, collectively ours, we have reporting requirements. And clearly, you just have to measure or else this could be money which is wasted.

So first, has SAMHSA put those state plan requirements in place for the Fiscal Year 2018 block grants? How are you measuring compliance by the states in terms of reporting? And how does SAMHSA take into consideration compliance with the reporting section and how well states are performing when they decide to award a grant?

Dr. MCCANCE-KATZ. So we have a required Government reporting system that is used by all of our grantees, including the states, in the block grant funding.

I will tell you that I am not satisfied with the data as it is currently collected. I think that we could do a much better job of get-

ting information, and that requires a certain set of steps that we need to go through.

But I will tell you since I have started, we have made good progress on that, and we will be approaching the OMB to further hone those questions that will be more informative about programs.

Senator CASSIDY. Now, let me ask as well, because I have actually spoken to colleagues about this.

Medicaid is not required to robustly report data. I understand when it comes to mental health, it is called braiding of SAMHSA block grants with Medicaid dollars, with Medicare dollars, et cetera. And it is all put together for a package.

CMS has one set of reporting requirements and SAMHSA has another.

Has there been any initiative between SAMHSA and CMS to somehow coordinate these reporting requirements, perhaps to unlock some of what CMS holds, but SAMHSA could use?

You see where I am going with this?

Dr. MCCANCE-KATZ. I do see where you are going with it, and what I can tell you is this.

Part of the role of the Assistant Secretary position is to reach out to other divisions, other agencies, other departments. And so, I have asked for a meeting with CMS. That will be happening soon and this is one of several topic areas that we will be addressing.

I have talked to folks at SAMHSA about this. They say this is a big hurdle. That they do not know a way that we could, right now, pair those data, because I do understand what you are getting at. But I will be talking with CMS about that and see if we cannot bring people together to look at that.

Senator CASSIDY. Let me just also say, again, as I said in the beginning, this is about collaboration and cooperation.

I suspect Senator Murphy, but certainly my staff, would love to meet with your staff as to how we facilitate that. Because right now, we are paying a lot of money as the Federal Government for Medicaid and we have some pretty poor outcomes in Medicaid. When you control for everything, you still have poor outcomes.

And so, we need to have better reporting requirements and if it takes a statute to make that happen or some sort of oversight, sometimes that just makes it work better.

Do you want to work on that?

Senator MURPHY. Okay.

Senator CASSIDY. So at least Murphy's and Cassidy's staffs would like to meet with your staff regarding that.

Dr. MCCANCE-KATZ. Got it.

Senator CASSIDY. Okay?

I have some other questions, but I am almost out of time.

So now, I think I go to Senator Franken.

Senator FRANKEN. Thank you, Mr. Chairman.

Good to see you again, doctor.

When I meet with people in Minnesota who are struggling with mental illness and substance use disorders, I often hear about the stigma people experience. Mental illnesses are often not regarded as physical conditions. Rather sometimes seen as moral failings, and we all know that is just not the case.

My predecessor, Senator Paul Wellstone, made it his life's work to fight for people with mental illness, pushing ceaselessly for mental health parity. One of my greatest honors, as Senator from Minnesota, has been to carry forward his work on mental health and championing policies that promote parity.

I am proud that the Affordable Care Act expanded parity protections to people who do not have employer sponsored coverage and seek care through the individual market. And the 21st Century Cures Bill extends these efforts by calling on the Federal Government, and other key stakeholders, to generate an action plan to improve enforcement of mental health parity laws.

Dr. McCance-Katz, in your testimony, you referred to the listening session that the Administration held this past July. Patients, advocates, and providers explained that many times, people cannot find in-network providers, face high out of pocket costs, and have to fight with insurance companies just to get services covered.

Stakeholders called for more enforcement, transparency from insurance companies, and agency guidance.

The actions the Administration has taken thus far fall short of these demands.

What will you commit to doing in your new role to improve transparency from insurance companies and transform the Parity Portal into a meaningful resource for consumers?

Dr. MCCANCE-KATZ. Yes, thank you, Senator Franken.

I will tell you, that is a work in progress.

One of the reasons that I agreed to come back into Federal service is because I want to advocate for people living with mental and substance use disorders. And so, I am going to be an advocate for as long as I am in this position.

One of the things that, I think, is very important is for people to be able to get access to care, and when they have barriers that are put in place by arbitrary insurer limits, it is unfair.

So I am working with people at HHS around this Parity Portal to try to make it something that will be more functional for consumers.

Right now, it has been updated, so that at least people will be shunted to either social or to the Department of Labor, depending on what their problem is.

But I would like to see this be something much greater and something that consumers can actually use to get information.

Senator FRANKEN. Okay.

Dr. MCCANCE-KATZ. But it will take time.

Senator FRANKEN. I am so glad to hear you say that.

For years, we have heard a growing and urgent cry for help from clinicians and tribal leaders about the opioid epidemic and, in particular, its impact on Indian country.

That is why in the Indian Affairs Committee, I asked Indian Health Service Acting Director, Admiral Weahkee, how the Administration could address this issue and the opioid epidemic in Indian country more broadly.

He recommended that we first bring Tribes to the table, and second, consider community and culturally specific drug abuse prevention and treatment programs.



I pushed for language in the 21st Century Cures Act to ensure the leaders at SAMHSA consider the unique needs and circumstances of vulnerable subpopulations, including Native Americans, in their programs.

What are you doing to support and expand culturally based treatment programs for individuals living in Indian country, especially those suffering with opioid addiction and other substance disorders? And as part of your answer, can you describe how you are engaging with tribal communities and working to develop and implement these culturally specific programs?

Dr. McCANCE-KATZ. Yes. We actually have an Office of Tribal Affairs at SAMHSA. We have ongoing meetings with tribal leadership.

When I came to SAMHSA, I learned that one of the Addiction Technology Transfer centers that was specifically put in place to assist tribal nations was going to end. That has now been funded. There is a funding announcement out.

Senator FRANKEN. Very good.

Dr. McCANCE-KATZ. We will choose a grantee who will work with Tribes and meet their cultural needs as well as their substance abuse needs.

We also work, as I mentioned, with the Indian Health Service. Our Chief Medical Officer is meeting with theirs and working with them around what kinds of technical assistance and training needs do they recognize and that SAMHSA can help them with.

We have, and I will not take a lot of time, but we have a lot of training programs that really are quite good.

Senator FRANKEN. Yes, thank you, because I am out of time.

Before the hearing, I spoke to you about supportive housing.

Dr. McCANCE-KATZ. Yes.

Senator FRANKEN. I want to continue that conversation with you even as I leave this body because, I think, that is very important that people with mental health disorders, and with addiction, get supportive housing and wraparound services.

So thank you for engaging in that conversation before the hearing.

Dr. McCANCE-KATZ. Thank you, sir.

Senator FRANKEN. Thank you, Mr. Chairman.

Senator CASSIDY. Senator Whitehouse.

Senator WHITEHOUSE. Thank you, Chairman. Appreciate it.

Dr. McCance-Katz, welcome. Good to see you again before the Committee.

Dr. McCANCE-KATZ. Thank you.

Senator WHITEHOUSE. We, in the negotiations around CARA and the Cures Act, got a bipartisan commitment for an extra billion dollars to be spent on opioid treatment.

The first half of that was already distributed and we hope, and expect, that the second half of it will come through in the end of this year's funding measure, whatever that ends up looking like. We are very much counting on that.

In the last one, the measure by which the funding was distributed to states did not correlate to the rate of the opioid epidemic; the intensity and severity of the opioid epidemic in that state. Nor did it connect to the recently passed CARA bill.

I am hoping that, as we move forward on this, you will be in a position to structure the grant process for that second half billion in such a way that it more accurately addresses the high impact states and that it better connects to the CARA Bill. I think you can probably do that in the terms of the grant application request that you structure from SAMHSA.

I just wanted to hear from you where you plan to go with that, because the high impact states kind of got not treated so well.

Dr. MCCANCE-KATZ. So my understanding of this situation is that if we make any kind of changes to the previous funding announcement, then all states would have to reapply for the money.

I can just tell you that we have been hearing from lots of states about their concerns in having to reapply for the money, and the decision was made to not have any substantive changes in the second year of funding for that 2 years, that billion dollars.

Senator WHITEHOUSE. Yes.

Dr. MCCANCE-KATZ. Five hundred million each year.

Senator WHITEHOUSE. For the sake of the process convenience for all, the high intensity states are going to pay the price.

Dr. MCCANCE-KATZ. I would say a couple of things.

One, when that decision was made, I did go back, and we looked very hard, and we did find money, and we put a new funding announcement out that does prioritize those states that have been hardest hit by the opioid epidemic.

Senator WHITEHOUSE. Yes.

Dr. MCCANCE-KATZ. I will continue to do that.

In addition, the other thing that I have been able to do is to reallocate funding so that we are building a new Technical Assistance Program that will be individualized to every state.

So those states that are hardest hit, that have certain types of special needs, we will have local, technical assistance available to them that, we think, will be important to helping them implement as efficiently and effectively as possible.

Going forward from that 2 years of funding, whatever Congress and the President decide upon, we will look at that and we will be very much aware of the kinds of issues you have just raised.

Senator WHITEHOUSE. Please, also, be an advocate for additional spending in this area in the CARA programs in particular. I think we were able to get \$170 million in the last funding measure.

Dr. MCCANCE-KATZ. Yes.

Senator WHITEHOUSE. That is 2 percent of the \$8.6 billion that the pharmaceutical industry makes selling just the prescribed opioid products, setting aside the illicit stuff that comes over the border.

So 2 percent up against the devastation that we are seeing in the context of a multibillion dollar industry, I would consider a beachhead, not a victory.

I hope you agree.

Dr. MCCANCE-KATZ. Yes, sir.

Senator WHITEHOUSE. Last quick thing, this is a Rhode Island specific thing.

The Health Insurance Commissioner, as you know, in Rhode Island is taking a look at the mental health parity compliance of the

insurance companies in Rhode Island, and I know you are looking at that at the national level.

Can I just make sure that you have somebody on your staff coordinating with Rhode Island to make sure that you are supporting their work and everybody is pulling smoothly together on parity disclosure and enforcement?

Dr. MCCANCE-KATZ. Yes, so two things.

One, SAMHSA has developed a parity toolkit for insurance commissioners that we have made available to all the states.

Two, we have an office around healthcare reform issues, and we have a person who works individually with the states and with insurance commissioners within the states.

Senator WHITEHOUSE. Terrific.

Dr. MCCANCE-KATZ. So we will make sure that happens.

Senator WHITEHOUSE. Time is up.

Thank you. Appreciate it.

Senator CASSIDY. Chairman Alexander.

The CHAIRMAN. Thank you.

Dr. McCance-Katz, welcome.

I want to follow-up Senator Whitehouse's question because, if I remember right, it was his language that we put into the Cures Act to try to make sure that the money distributed took into account high impact states.

Am I not correct about that? At least I remember you talking about it.

Senator WHITEHOUSE. The problem is that it was based, as I understand it, on the number of opioid deaths among other.

The CHAIRMAN. Right, but we did put language in.

Senator WHITEHOUSE. And if it is a big state, you obviously are going to have a big number, but it does not necessarily mean that is a big impact.

The CHAIRMAN. Right.

So our intention, Dr. McCance-Katz, was to distribute money to high impact states. That was our intention and I believe Senator Whitehouse—

Senator WHITEHOUSE. I think the intention was not accomplished.

The CHAIRMAN. Yes.

What do we need to do to accomplish our intention?

You are saying that it would be impractical to cause all the states to reapply again. I can see that. But there will be more money coming for opioids. We do not know yet when, or where, or how much.

But is it the language about the difference between high impact states? I mean, the number of total deaths and the number of per capita deaths, is that the issue?

What kind of language would you recommend that we include in any new funding so that we direct money with a particular sensitivity to high impact states?

Dr. MCCANCE-KATZ. Senator Alexander, I was not here in the previous administration when the decision was made.

The CHAIRMAN. Yes.

Dr. MCCANCE-KATZ. However, my guess would be that they were trying to implement as Congress directed.

The CHAIRMAN. Right.

Dr. MCCANCE-KATZ. And I do not know that the—

The CHAIRMAN. Well, what would be a better way to do it? I am not trying to criticize them.

I am just trying to say if you were doing it today, how would you do it?

Dr. MCCANCE-KATZ. Yes, and so for the new funding announcement that we just put out, what we said was, what we were looking at was the rate of opioid overdose deaths within the state and the rate of increase year over year. That tells you how hard a state is being hit.

The CHAIRMAN. Okay.

Is that going to affect the second round of funding?

Dr. MCCANCE-KATZ. When the second round of funding comes forward, absolutely, we would be looking at different funding formulas.

The CHAIRMAN. I see. That does not require reapplication by all the states.

Dr. MCCANCE-KATZ. If it is a new source of funding? No. Everybody would have to apply for that funding and then we have—

The CHAIRMAN. Wait a minute. But the second round of funding, the other half.

Dr. MCCANCE-KATZ. I am sorry. The second, yes.

The CHAIRMAN. The second half billion dollars.

Dr. MCCANCE-KATZ. Sorry.

The CHAIRMAN. Does what you just described apply to that second half billion dollars?

Dr. MCCANCE-KATZ. So, no. We cannot—

The CHAIRMAN. But you would recommend that it, what you just said would apply to any new money.

Dr. MCCANCE-KATZ. Exactly.

The CHAIRMAN. Would you work with our staff so that if we write that properly—and if our intention is to recognize high impact states—that we do it in a correct way, and so we do not get surprised by it?

Dr. MCCANCE-KATZ. I absolutely will do that. Yes.

The CHAIRMAN. Okay, now let me ask you this. In 2014, Congress required states—I remember the discussion with Senator Whitehouse, and I wanted to see that his—we tried to implement his intention and we can keep working on that.

Senator WHITEHOUSE. Well, I am just so grateful that you followed up that way, Chairman.

The CHAIRMAN. Yes.

Senator WHITEHOUSE. I appreciate it.

The CHAIRMAN. Yes.

In 2014, Congress required states to set aside 5 percent of community mental health block grant funds for serious mental illness. The Cures Act increased that required to 10 percent.

Now, that sounds good, but that reduces the flexibility that states have to address what might be different in Rhode Island and California.

What is your opinion about the increase from 5 to 10 percent? Does that help or hurt the ability of states to respond to the needs of those with serious mental illness?

Dr. MCCANCE-KATZ. The vast majority of payments for the services delivered to people with serious mental illness is not from SAMHSA.

The block grant having that increase of 10 percent causes a focus on something that is extremely important, and that is early identification of first episode psychosis.

We know that the longer a person goes without having their psychotic thinking detected and treated, the more refractory their illness becomes over time. And so, that 10 percent and that block grant do a tremendous amount of good in terms of raising awareness of this important issue.

The CHAIRMAN. Well, how does that encourage early prevention, if the language is just to focus on serious mental illness, is it not or does it say something about “early”?

Dr. MCCANCE-KATZ. It talks about early identification of serious mental illness.

The CHAIRMAN. Early identification of serious mental illness.

Dr. MCCANCE-KATZ. Yes.

The CHAIRMAN. So it is not the “serious,” it is the “early” that is the key, really, to effective treatment.

Dr. MCCANCE-KATZ. But we consider psychosis to be serious.

The CHAIRMAN. Right.

Dr. MCCANCE-KATZ. To be indicative of serious mental illness.

The CHAIRMAN. So you think the 10 percent helps.

Dr. MCCANCE-KATZ. I absolutely do.

The CHAIRMAN. Because of the push toward early identification—

Dr. MCCANCE-KATZ. Yes.

The CHAIRMAN ———of serious mental illness.

Dr. MCCANCE-KATZ. Yes, and we know that the onset of most psychotic disorders is in adolescent and transitional age youth. So this is really very important to the lives that these folks will be able to live going forward.

The CHAIRMAN. Thank you, Mr. Chairman.

Senator CASSIDY. Senator Hassan.

Senator HASSAN. Thank you very much, Senator Cassidy.

Mr. Chairman, thank you for holding this hearing.

Dr. McCance-Katz, thank you so much for being here and for the work you do.

I want to follow-up on the conversation we were just having about funding for those of us who are from states that have been incredibly, disproportionately impacted by a horrible epidemic that is taking lives, obviously, across our country.

But in New Hampshire, our Fentanyl, heroin, and opioid epidemic is referred that way because it is Fentanyl that is killing people in my state at one of the highest, if not the highest, per capita death rates in the country. And we have been targeted by Fentanyl dealers.

I was at a funeral Saturday where a family buried their second daughter from an overdose. A woman who had been in recovery and had been working really hard at it, and this disease is taking all of our efforts.

I am very, very grateful to everybody on this Committee. But I will add my concerns and frustrations to what you heard from Senator Whitehouse.

I have expressed them directly to the Secretary. I think the fact that states were uncomfortable about reapplying is not an excuse in terms of the decision that was made with the second round of this funding.

Toward that end, Senator Alexander, Senators Capito, Coons, myself, and Senator Manchin have a bill in called the Targeted Opioid Funding Act that would change the formula and make clear what kind of priority we should give to per capita death rates. And I would love the Committee's attention and collaboration on the bill.

But even if we fix this formula under the Cures Act, we know that the Cures Act money right now is only for 2 years, and we know that there is no quick fix for this epidemic.

We desperately need funds to fight this epidemic. We need the Administration to tell us what supplemental resources it is proposing to turn the tide.

I was appreciative of being at the White House in October when the President declared this a public health emergency. But so far, we have not seen any follow-up to that declaration, and we have seen no proposal from the Administration for the funds that we need to tackle this epidemic everywhere in our country.

An epidemic that is not only taking lives, but in New Hampshire, I think the year was 2014 or 2015, cost us over \$2 billion in our economy.

So Dr. McCance-Katz, have you had conversations about the need for additional funding with HHS and the White House? Why has this Administration not called for additional funding or proposed additional funding so we can get the dollars and the resources to the frontlines where it is so needed?

Dr. MCCANCE-KATZ. Senator Hassan, I think that there are many conversations going on about what the needs are and lots of efforts to look at the data that is available, the information that is available.

It is my understanding that the Administration is very interested in working with Congress on developing those ideas that might be something that both the President and Congress can agree upon to bring more resources to bear.

Senator HASSAN. Well, this Congress has made very clear that we support additional funding to fight this, but we really need a partner in the Administration to stop talking and start funding.

I would look forward to continuing those conversations.

I also wanted to follow-up with another question, because we know how complex the opioid use disorder is. It is often accompanied by a variety of mental health disorders including, for example, Posttraumatic Stress Disorder.

This leads to complex and sometimes very dangerous outcomes. Veterans and other populations with PTSD and co-occurring pain conditions are often prescribed higher doses of opioids, putting them at a greater risk for accidental overdose and deaths.

Treating one disorder, obviously, does not address symptoms of the other. It is imperative that we work to ensure that patients

have access to comprehensive treatment to address both substance use disorders and mental health needs.

Doctor, have the mental health provisions in the 21st Century Cures Act helped SAMHSA enhance the availability of evidence-based treatment programs for dual diagnosis of mental health disorders and opioid use disorder?

Dr. MCCANCE-KATZ. Yes, I believe they have. And specifically, I can speak to the issue around the Department of Defense and Veterans Affairs which Cures addressed, and which has developed into a very strong relationship where SAMHSA works collaboratively in an ongoing way.

We specifically address the issues of mental disorders and the opioid epidemic, as well as suicide. Those are the big issues that we are working on right now.

We also can use the information that we learn from the V.A., which actually does a lot of research of its own.

Senator HASSAN. Right.

Dr. MCCANCE-KATZ. We share this, and we promulgate it to communities.

Senator HASSAN. Well, I thank you for that, and I thank you for the vision of the integrated healthcare in this area.

I am most concerned that we are delaying some of our work that would be made possible with extra funding because of the stigma attached, as many of the other Senators have referenced, and I appreciate very much your efforts.

Dr. MCCANCE-KATZ. Thank you.

Senator CASSIDY. Senator Young.

Senator YOUNG. Doctor, good to see you.

I read a book some months ago by Sebastian Junger. It is a small, little book called, "Tribe," and he discusses in the book the challenges our veterans face as they try and reintegrate back into society.

He makes the point that from an evolutionary standpoint, we are more comfortable in tribal societies, like military platoons embedded in a military structure, than we are in the current atomized society where people tend to feel lonely. And so, there are challenges of reintegration and adaptation.

So he turns on its head the challenges our veterans are facing. The problem is not, per se, with the veteran, but it may be with the broader society. It is a really interesting read.

When I lay that line of argument, that analysis, on top of the study, the "Deaths of Despair" study that indicates we see increasing rates of morbidity among middle aged men, white men in this country. And the reason for the deaths is heightened suicide, alcohol use, and so forth. I start to think that loneliness is really driving so many of the mental health issues in our country.

Could you just give me your assessment of that, perhaps, popular reading of the literature?

Dr. MCCANCE-KATZ. So I do think that those are important points.

I actually think that there is research data that says that people who are isolated, who will endure loneliness and feeling ostracized within their communities die at much younger ages. So that is an important issue.

Senator YOUNG. It is a driver, is what I am hearing, a driver of some of our mental health challenges.

Are there evidence-based approaches to intervening in this problem; if not solving it, then mitigating the challenges? And if so, what is that evidence base? What interventions work?

Dr. MCCANCE-KATZ. Yes.

Senator Young, I think that this is a topic in evolution, but I do think there is some accumulating evidence for the value of recovery supports as they relate, not only to substance use disorders, but to mental disorders.

One of the things that I am working on, and this is one of my priorities, actually, is to bring psychiatric medicine into closer contact and collaboration with community recovery supports.

It is not enough to just provide medical care as psychiatric medical care. People need those recovery supports in their communities. They can be veteran-based. They can be faith-based.

Senator YOUNG. Right.

Dr. MCCANCE-KATZ. Yes, so you get where I am going with that.

Senator YOUNG. Yes.

Dr. MCCANCE-KATZ. I think that will go a long way toward assisting people to live the fullest life they can.

Senator YOUNG. It just seems consistent with common sense that there is more needed than medicating these problems away.

People need genuine human contact. They need relationships that are meaningful to them. They need to feel like they are part of a broader community, a meaningful part.

I just have a couple of minutes left. If we could turn to how the Federal Government incorporates, or fails to incorporate, feedback loops in terms of addressing mental health and the policies we have.

There was a recent "Governing" magazine article on this written by a health economics professional at Harvard Medical School, and a former Obama administration official.

The authors advocate for including a tiered evidence approach with Cures dollars to allow for scaling up of evidence-based approaches, while concurrently supporting field-generated innovations.

Have you considered including a tiered evidence approach in some of your programs, say, the National Mental Health Substance Use Policy Lab?

Dr. MCCANCE-KATZ. Thank you for that question, Senator. And I think we spoke a little bit about this when I was going through the confirmation process.

Senator YOUNG. But I want to publicly speak about it.

Dr. MCCANCE-KATZ. Yes, and so, the answer to your question is yes, we are.

I am very happy to be able to tell you that the Policy Lab is being stood up now. We have hired a Director who is, I think, a very experienced and knowledgeable person who is going to do exactly that kind of work.

Senator YOUNG. Well, great. I continue, of course, to have great interest in this and we will be following up with you, and your staff, to see how it might be supported from a legislative standpoint.



Dr. MCCANCE-KATZ. Thank you.

Senator YOUNG. Thank you, Chairman.

Senator CASSIDY. Senator Franken.

Senator FRANKEN. Thank you, Mr. Chairman.

I was glad to hear you talk about recovery supports. We had Rebecca Boss from Rhode Island. I know you are from Rhode Island.

Dr. MCCANCE-KATZ. I used to work for her.

Senator FRANKEN. Yes, and she was doing unbelievable work.

Dr. MCCANCE-KATZ. Right.

Senator FRANKEN. I know she talked in Rhode Island, they have recovery coaches.

Dr. MCCANCE-KATZ. Yes.

Senator FRANKEN. That is what they are called and do exactly what you are talking about in getting into the community.

One of the things that we put in 21st Century, into the Cures Act, is more crisis intervention training for police.

We talked before the hearing about Judge Leifman, Steven Leifman in Miami Dade has implemented a system where people with mental illness and substance abuse who get arrested. Instead of going to jail—which they used to do and which costs a tremendous amount of money or going to emergency rooms, which also costs a lot of money—is getting them housing and getting them wraparound services.

That is something that, I know Senator Young and I have talked about housing as a way. We have done this in Hennepin County in Minnesota as well.

But that is something that I want Senator Young and others on this Committee to keep advocating for and keep thinking about. I will be bugging you even from outside.

I want to talk about Indian country again and Senator Hassan talked about PTSD and talked about trauma. We see a tremendous amount of trauma in Indian country, not just the historical trauma, but the trauma of extreme poverty, of domestic violence, of drugs, and sexual abuse, and all of those things. And so that is why we see such high incidents of opioid deaths in Indian country.

I went to a rehab for teenagers in North Minnesota a couple of years ago. I have visited a number of rehabs and I had never seen such, kind of hopelessness from these in rehab. Usually when you go to rehab, there are people feeling hope at a certain point.

What I really got was that these kids, most of them, it started with use with their parents. And the hopelessness that I saw was what they were going back to. And this is true also outside Indian country.

I was in Rochester, Minnesota where we had a roundtable on opioids, and a woman whose daughter had got treatment, went back, fell in with the old crowd, and is now gone.

One of the things that I was thinking of, again with housing, is a model of, and maybe piloting this, of a sober living housing in Indian country where, instead of going back to the home where you were living, going to a facility that has people like you. And it can be very close to the Reservation or on the Reservation.

But where you are getting continuous support, and you are being tested, and you are going, and you have a fellowship of the people there who are living sober too. Because especially opioids, this is

a long, long, long term thing. It is not, what, 5 days of detox and then 28 days. It is a much longer thing than that.

That is something that I would really like to advocate for going forward.

One last thing about culturally specific in Indian country. I think it is very important, but I did a roundtable in Minneapolis and one of the providers there, one of the counselors said to me. I said, "What does that mean, culturally specific?" And she said, "When an Indian woman sees me as her counselor, because I am Indian, she knows that I know what she has been through."

I think that culturally specific means more than just a cultural thing. I think it means, actually, in Indian country making sure that we train the providers.

Thank you.

Dr. McCANCE-KATZ. Yes, and I agree with you. Yes, you are quite right.

Senator FRANKEN. Thank you, Doctor.

Senator CASSIDY. Senator Warren.

Senator WARREN. Thank you, Mr. Chairman.

Dr. McCance-Katz, one of the most important things we did in Cures was to create an Office of the Assistant Secretary of Mental Health and Substance Use, which is now what you have been nominated to head up.

We need to ramp up our response to the opioid epidemic, and that means using every single tool in the toolbox. And one tool is to put more resources into mental health.

Can I ask you to tell us why it is so important that we address mental health if we want to beat back the opioid crisis?

Dr. McCANCE-KATZ. Yes, and thank you for that question, because there is such a very high rate of co-occurring mental disorders with substance use disorders. And the genesis of these mental disorders often predates the substance use disorder itself. We also know that if we do not address both disorders—treating one does not treat both.

Senator WARREN. Good. That is a very succinct way to put it, and I appreciate that.

It is clear that making progress on the opioid crisis means putting resources into treating mental health disorders.

Medicaid is the largest funding source for mental health services, but SAMHSA has a number of other programs that help fund services that are not covered through public or private insurance.

The mental health services block grant, and a group of other grant programs called the Programs of Regional and National Significance, are SAMHSA's main mental health programs providing funding for all 50 states and supporting the work of mental health agencies of local government and of nonprofits who are working in this area.

These programs are absolutely critical to improving mental health in this country and they serve millions of Americans. But let me ask you, Dr. McCance-Katz.

Is everyone who needs mental health care able to get that help right now?

Dr. McCANCE-KATZ. I would say the short answer to that is no.

Senator WARREN. No? And why not?

Dr. MCCANCE-KATZ. There are a variety of reasons.

One thing we know is that a lot of people, who we would say need this kind of assistance, do not want it. But then there are also barriers that prevent people from getting the care and treatment that they need. It can be very difficult to access care.

Senator WARREN. Right. Do you have an estimate on how many people need mental health treatment who are not able to get it?

Dr. MCCANCE-KATZ. I think our NSDUH data told us somewhere about 12 to 13 million people.

Senator WARREN. Yes, that is really a stunning, stunning number.

Now, the Mental Health Services Block Grant, and the Programs of Regional and National Significance, are SAMHSA's two largest mental health programs. Combined, we spend less than a billion dollars a year on those programs. So let me ask you.

The White House Counsel of Economic Advisors released a report last month estimating the cost of the opioid crisis to this country.

Do you know what figure they came up with?

Dr. MCCANCE-KATZ. I am guessing it was pretty high.

Senator WARREN. It was pretty high, \$504 billion.

Think about that. The cost to this country annually of the opioid crisis is more than half a trillion dollars. That is in 2015 alone. That is where we have the most recent data.

We are investing only one-fifth of 1 percent of that amount in helping SAMHSA tackle the mental health piece of this problem.

I think we need to do more and that is why I have called for an additional billion dollars of funding in next year's budget. That would double SAMHSA's budget and let them double what they put into the two largest mental health programs.

Yesterday, the National Council, which represents 2,900 mental illness and addiction organizations, wrote me a letter and I just want to quote what they said. They said, "Now is the time to support the highest possible levels of funding for healthcare programs in the Federal budget."

Today, this morning, the Massachusetts Association for Behavioral Health Care sent me a separate letter requesting that Congress double these funds.

I could not agree more that doubling the funds for these mental health programs would give millions more Americans access to the treatments that they need and it would start making a dent in the astronomical costs that the opioid crisis is imposing on our country.

Thank you for being here.

Thank you, Mr. Chairman.

Senator CASSIDY. Senator Kaine.

Senator KAINE. Thank you, Mr. Chair.

It is good to have you with us, Dr. McCance-Katz.

I want to ask about the issue that I hear about all the time in Virginia from my law enforcement community and that is the intersection between mental health and people who are in jails and prisons who should not be.

I have a lot of tough sheriffs, tough law enforcement sheriffs and police chiefs who lament the fact that their jails are filled with people who have diagnosed, but untreated, or sometimes never diagnosed, mental health conditions.

They feel that these people should not even be in jail, but if they are not treated, they are going to do something to harm themselves or others, they will end up in jail.

They feel like they are being asked to be the mental health provider for a society that does not fund mental health services. And they feel both sort of a compassionate anger about that, but also a resource challenge that makes it harder for them to do their job. And so, I really want to ask about that.

I also talk to police chiefs sometimes after high profile incidents, a police shooting of somebody, for example. And they will say, "At bottom, some of this was the police approach. Somebody had a mental health need and we are not completely trained on that." And then it spiraled into something worse, and then that can often become a flashpoint for community anger.

But at the bottom of it, there was an untreated mental health issue. So that is what I want to talk to you about.

The 21st Century Cures Act has some important provisions around mental health and the criminal justice system including an Interdepartmental Serious Mental Illness Coordination Committee; that is a long acronym. And a provision that called for the Attorney General to establish a pilot program to determine the effectiveness of diverting eligible offenders from the Federal court system, Federal courts and prisons, into drug and mental health courts.

Can you tell us a little bit about work the Coordinating Committee is doing in conjunction with the criminal justice system? And has the Attorney General, and the Department of Justice, been supportive in these efforts?

Dr. MCCANCE-KATZ. So a lot of questions there, but yes.

So ISMICC, we call it the ISMICC, the Interdepartmental Serious Mental Illness Coordination Committee includes the Department of Justice. They have been good partners with us and we expect that to continue.

As you know, this is a 5-year process. You will be getting that Report from the Committee today.

Senator KAINE. Right.

Dr. MCCANCE-KATZ. And the issues around the interface between serious mental illness and the justice system are one of the primary areas of focus within that Report.

I will just tell you also that we have programs at SAMHSA that are dedicated to diversion and mental health courts. We have programs for offender reentry so that they do not get lost through the cracks.

Because my own experience—having run the state hospital system in Rhode Island, where we worked with the Department of Corrections—was that we frequently would get folks back because they did not get into appropriate outpatient care at the time they were leaving.

Senator KAINE. Right.

Dr. MCCANCE-KATZ. Even though we might provide treatment to them, while they were incarcerated, that stopped.

So the ISMICC has addressed this. I hope you will be pleased with some of the recommendations that we will be working on.

Senator KAINE. I very much look forward to reading it. The thing that I am sort of most familiar with at the state level is the use of mental health courts, which are significant.

Can you talk a little bit about how the mental health court system is working at the Federal level, some of the things that we might be reading in the ISMICC Report about that?

Dr. MCCANCE-KATZ. Well, what you will be reading is that we need more, more of these types of programs. And these programs are very effective in diverting people away from incarceration and into treatment, appropriate care, including medication because a lot of these individuals need medication have not gotten it and do not continue to get it.

That is also part of what the ISMICC committee has recommended that the issues around civil commitment laws be looked at to try to maintain a person in care once they leave.

Also, the other thing that we talk about in the Report is the Crisis Center, the use of a crisis center that is specifically geared to the treatment of people who have substance use and mental disorders, rather than going to an emergency department, which is not an appropriate placement and where law enforcement often gets stuck.

Senator KAINE. Right.

Dr. MCCANCE-KATZ. These kinds of interventions can be very helpful in freeing up law enforcement and getting people the care they need.

Senator KAINE. Right.

Mr. Chair, I have one more question, if I could ask. I am near the end of my time, if others want to jump ahead for a second round. Should I just go ahead?

I want to ask you about co-prescription of Naloxone. I know many of the questions you have been asked have been about opioid issues.

I have worked with colleagues to introduce a Co-Prescribing Save Lives Act which was incorporated, partially, into the CARA. I was pleased to see that was a very bipartisan effort.

How much progress has been made in terms of making Naloxone more available to at-risk populations? Can you speak to the availability of prescribing guidelines?

Dr. MCCANCE-KATZ. Prescribing guidelines, we have at SAMHSA an Opioid Overdose Prevention Toolkit that speaks to the use of all of the available formulations of Naloxone.

That is in the process of being updated right now because there have been some recent FDA approved formulations. So that is available.

We also encourage co-prescribing. We train on co-prescribing and we have, through CARA and through Cures, we have programs available that train first responders and also provides for funding for purchase of Naloxone and distribution of Naloxone.

Senator KAINE. Thank you, Mr. Chair.

Senator CASSIDY. Yes.

Dr. McCance-Katz, I have kind of a follow-up. It is a follow-up, not only to what I asked earlier, but actually to a previous hearing where you were talking about opioids.

In my previous line of questioning, I was asking about, how do we monitor outcomes? The last Committee hearing I asked, how do we monitor a specific program?

If we have Treatment Program A and Treatment Program B, and Treatment Program A has a high recidivism rate with a lot of folks being, perhaps, overdosing in an emergency room 2 weeks after discharge. We have Program B where they have a more effective approach and we do not see that sort of thing on billing data or however.

I had asked you last time if SAMHSA was instituting those kinds of review processes. I think the answer I got, "Great idea, but probably not at this point."

In relation to what I asked earlier, is it possible for SAMHSA to do that without a cooperative agreement with CMS to look at billing data, to see if there is some marker of recidivism?

For example, a billing for an emergency room visit a week after discharge. You follow what I am saying.

What I am really trying to get at is how do we effectively look at programs that are treating folks for addiction to know whether or not those programs are effective and the taxpayer gets the best deal for her dollar, but more importantly or as importantly, the patient gets the best outcome relative to recovering from their addiction?

Thoughts?

Dr. MCCANCE-KATZ. The issue around CMS and their billing data is one that we have to work on, but yes.

I am reviewing all of SAMHSA's data collection programs right now, and we are going to be making that data more available publicly. So it is not just a matter of do programs—

These would be our programs that we are funding. But it is not just a matter of collecting that data so that we can see whether the programs are good, but making it available to the public.

We are working with our Center for Behavioral Health Statistics and Quality to look at means by which we can make that data more available.

The other thing that we do is I will tell that you for the STR program, I am a clinician.

Senator CASSIDY. STR is?

Dr. MCCANCE-KATZ. STR is, I am sorry, it is the State Targeted Response. It is the \$500 million a year for each of 2 years.

I am a clinical and I love clinical work. I am meeting with my staff about every single grantee. We are looking at every single program to see how the states are using their money. They are all doing it differently.

Senator CASSIDY. So let me ask.

Dr. MCCANCE-KATZ. Yes.

Senator CASSIDY. In follow-up, if states are doing it differently, is there a common way that you can say, "This is how we wish you to evaluate"?

Because really, absent billing data that apparently is only available from CMS, it seems like it can be very difficult to evaluate recidivism rates. Is somebody moving to another locale? Many of these treatment programs are at a geographic distance from the place where the patient began. Right?

If there is a way to evaluate without billing data, one, does it exist? Two, is CMS promulgating this? As, “Listen. We want you to evaluate and this is how we wish you to do so.”

Dr. MCCANCE-KATZ. Yes. The answer to your question is we have several evaluations of this program ongoing. We are monitoring the states to make sure that they are using evidence-based practices.

We have one evaluation that is being done by CDC. We have another that is being done by a contractor. That data will be made available publicly. So that is an ongoing project for SAMHSA.

Senator CASSIDY. By the way, I do not personally think the data should be used punitively. It could be also total quality management.

Dr. MCCANCE-KATZ. The other thing that we do is that because we are working so closely with the states—and because we have a new program of technical assistance—we will also be asking the states to bring forward data on their programs because they have the ability to see whether their programs are working.

Senator CASSIDY. When will this data be available for the general public or for Congress to review, the first set of it?

Dr. MCCANCE-KATZ. I do not know the exact answer to that, but I will find out and get to you about that.

Senator CASSIDY. Fantastic.

Senator Murphy.

Senator MURPHY. Thank you very much.

A few follow-up questions I wanted to ask too on the challenge of broadening our mental health workforce.

Senator Kaine accurately talked about diverting individuals out of the criminal justice system. Often, your first interaction with the criminal justice system happens at school.

Many kids with mental illness will misbehave at school, will run into a police officer, and be sucked into the criminal justice system never to emerge.

We talk a lot about mental health first aid training.

To the extent that schools have police officers onsite, should not every single school-based resource officer have some basic training in identifying mental illness so that they can divert kids away from jails and into treatment if they present with symptoms?

Dr. MCCANCE-KATZ. Yes, and without endorsing a particular program.

Senator MURPHY. Right.

Dr. MCCANCE-KATZ. Yes, I believe that is the best way to approach that issue. Absolutely.

Senator MURPHY. Then, tell me about SAMHSA’s work to develop more peer capacity.

Peers occupy a very specific and useful role in treatment, lots of emerging data telling us that for many people in recovery that peer connection is what matters most.

Give me an initiative that SAMHSA is working on now to try to broaden and improve the quality of peers on our system today.

Dr. MCCANCE-KATZ. So SAMHSA has had a pretty substantial role in the development of the peer workforce.

However, it is my view that no Government agency should be in the business of trying to figure out how to accredit a particular type of workforce.

What we are doing is we have an office for consumers and families that is working with some national organizations on developing criteria for accreditation of peers. The states are all different. They do it differently, but we are working with states and with the stakeholders to move that process along.

I believe that peers need to be integrated into the healthcare team because it is so important to not just give medical care, but also the recovery services.

That is what we are working toward.

Senator MURPHY. One last question, follow-up on a conversation you were having with Senator Cassidy.

You mentioned that you were not satisfied with the data that you are receiving from states. I think that is in relation to the block grants.

Can you just tell us why you are not satisfied with the data that you are getting? Is it the amount of data or the quality of data? What is the problem that you are seeing?

Dr. MCCANCE-KATZ. Because the data does not tell us anything about diagnoses and it does not tell us anything about really basic standard of care issues, like, did a person get medication-assisted treatment?

How do I know if a program is working if I do not even know if they got the standard of care? We are changing that.

Senator MURPHY. So what are you getting right now?

Dr. MCCANCE-KATZ. We get the number of people served. We get things that approximate certain types of diagnoses. Did you feel sad? Do you use certain substances?

But that is not enough to tell us what these programs are doing for whom, and what does and does not work.

Senator MURPHY. Thank you for your focus on data. I agree with Senator Cassidy that to the extent we can avoid duplication in requirements to the states on this, it is something we should work together on.

Senator CASSIDY. I would echo that and I thank the Administration for appointing you, because you seem as irritated about some things that I am irritated about, and they are good things to be irritated about.

I want to finish by thanking Senators Alexander, Murray, and Murphy for calling, convening, and participating in this.

I also thank you, Dr. McCance-Katz, for an excellent testimony.

The hearing record will remain open for 10 days. Members may submit additional information for the record within that time, if they would like.

Senator CASSIDY. Thank you for being here today.

The Committee stands adjourned.

[Whereupon, at 11:28 a.m., the hearing was adjourned.]