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TRANSFORMING MENTAL HEALTH AND SUBSTANCE ABUSE SYSTEMS OF CARE: COMMUNITY INTEGRATION AND RECOVERY

HEARING

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

UNITED STATES SENATE

ONE HUNDRED TENTH CONGRESS

FIRST SESSION

ON

EXAMINING COMMUNITY INTEGRATION AND RECOVERY, FOCUSING ON TRANSFORMING MENTAL HEALTH AND SUBSTANCE ABUSE SYSTEMS OF CARE

MAY 8, 2007

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TRANSFORMING MENTAL HEALTH AND SUBSTANCE ABUSE SYSTEMS OF CARE: COMMUNITY INTEGRATION AND RECOVERY

TUESDAY, MAY 8, 2007

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

The committee met, pursuant to notice, at 10 a.m. in Room SD–628, Dirksen Senate Office Building, Hon. Jack Reed, presiding.

Present: Senators Reed, Murray, Enzi, Burr, and Murkowski.

OPENING STATEMENT OF SENATOR REED

Senator REED. Let me call the hearing to order and first say that Senator Kennedy very much wanted to be here today, but he has been asked to represent the United States at a very historic meeting in Northern Ireland where, for the first time in our recollection, two opposing forces have come together to form a unity Government, and I can't think of anyone more appropriate to represent this country than Chairman Kennedy.

But, we're lucky to have my friend and colleague, Patrick Kennedy, who will be our first witness, so let me make an opening statement and then turn it over to Senator Enzi, and then recognize Congressman Kennedy.

I'm pleased to chair this morning's Senate HELP Committee hearing on SAMHSA, or the Substance Abuse and Mental Health Services Administration, and its upcoming reauthorization by this committee.

It has been 7 years since Congress last reauthorized SAMHSA. With this reauthorization, we have the opportunity to assess the success of the programs we initiated in the last SAMHSA reauthorization, as well as address some of the new challenges that SAMHSA faces. I look forward to learning more about how SAMHSA has carried out its mission since that time, and the types of issues that SAMHSA is currently facing and addressing. And, I also look forward to working with the Chairman, Ranking Member, Senator Enzi, and other HELP Committee colleagues as we consider the various initiatives during the SAMHSA reauthorization process.

I'm particularly interested in improving the network of community health providers, to strengthen the links between housing and supportive services for homeless populations with substance abuse and mental health disorders, and to explore ways to enhance the

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workforce pipeline in the mental health and substance treatment fields.

SAMHSA provides valuable services to help prevent, detect and treat people with, or at risk for, mental health or substance abuse disorders. This is a significant task on many levels. It is estimated that more than 44 million Americans have a mental disorder, 22 million Americans have a substance abuse problem, and 7 to 10 million have co-occurring mental health and substance abuse disorders.

The importance of SAMHSA funding services is sadly underscored by the recent tragic events at Virginia Tech. Mental illness and substance abuse are major National problems, and they deserve our close attention and strong support.

Substance abuse and mental health problems can have a detrimental effect on an individual's personal and professional relationships, as well as on their overall physical health. A recent report examining eight States, including my home State of Rhode Island, found that Americans suffering from mental illness die between 10 and 25 years sooner than average Americans. Although the mentally ill have high accident and suicide rates, about three out of five die from mostly preventable diseases.

The report also reveals that persons with mental illness were far more likely to smoke or have substance abuse problems. Yet, unlike a broken bone or other physical illness, those who suffer from mental illness and substance abuse problems often go undetected, even by those closest to them.

SAMHSA is charged with the critical, and sometimes difficult task of improving our systems of detection and treatment, so that we can help people before their problems get worse. And while we've made significant progress toward reducing the stigma associated with mental health and substance abuse problems, we have more to do. The services that SAMHSA provides are vital to detecting and combating the problems associated with mental illness and substance abuse. Congress has an opportunity to improve SAMHSA's ability to serve the millions of Americans who suffer as a result of mental illness and substance abuse.

This morning, we will hear from three panels, including my distinguished colleague and friend, Representative Patrick Kennedy, of Rhode Island, and then we'll have a second panel with Dr. Terry Cline, the SAMHSA Administrator, and our third panel will be composed of Lisa Halpern, Program Director for the Dorchester Bay Recovery Center; Rodger McDaniel, Executive Director of the Wyoming Mental Health and Substance Abuse Service Division; and Terry Lee Allebaugh, Executive Director of Housing for New Hope, Incorporated.

During this hearing, I hope we can gain, and I do believe we will gain, a deeper understanding of SAMHSA and I look forward to the testimony of all of our witnesses. Let me recognize now, the Ranking Member, Senator Enzi.

Senator.

[The prepared statement of Senator Reed follows:]

PREPARED STATEMENT OF SENATOR REED

Good morning. I am pleased to chair this morning's Senate HELP Committee hearing on SAMHSA, or the Substance Abuse and Mental Health Services Administration and its upcoming reauthorization by this committee.

It has been 7 years since Congress last reauthorized SAMHSA; with this reauthorization we have the opportunity to assess the success of the programs we initiated during the last SAMHSA reauthorization as well as address some of the new challenges SAMHSA faces. I look forward to learning more about how SAMHSA has carried out its mission since that time, and the types of issues that SAMHSA is currently facing and addressing. I also look forward to working with the Chairman, Ranking Member and other HELP Committee colleagues as we consider the various initiatives during the SAMHSA reauthorization process.

I am particularly interested in improving the network of community mental health providers, strengthen the links between housing and supportive services for homeless populations with substance abuse and mental health disorders, and exploring ways to enhance the workforce pipeline in the mental health and substance treatment fields. Chairman Kennedy regrets his absence today from such an important hearing but he has been asked to represent the United States in the historic proceeding taking place in Northern Ireland with their peace agreement.

SAMHSA provides valuable services to help prevent, detect and treat people with or at risk for mental health or substance use disorders. This is a significant task on many levels. It is estimated that more than 44 million Americans have a mental disorder, 22 million Americans have a substance abuse problem and 7 to 10 million have co-occurring mental health and substance use disorders.

The importance of SAMHSA funded services is sadly underscored by the recent tragic events at Virginia Tech. Mental illness and substance abuse are major national problems and they deserve our close attention and strong support. Substance abuse and mental health problems can have a detrimental affect on an individual's personal and professional relationships as well as on their overall physical health.

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Yet, unlike a broken bone or other physical illnesses, those who suffer from mental illness and substance abuse problems often go undetected, even by those closest to them.

SAMHSA is charged with the critical and sometimes onerous task of improving our systems of detection and treatment so that we can help people before their problems get worse.

While we have made significant progress toward reducing the stigma associated with mental health and substance abuse problems, we have more distance to cover. The services that SAMHSA

provides are vital to detecting and combating the problems associated with mental illness and substance abuse and Congress has the opportunity to improve SAMHSA's ability to serve the millions of American's who suffer as a result of mental illness and substance abuse.

This morning we will hear from three witness panels that include my distinguished colleague Representative Patrick Kennedy, Dr. Terry Cline, SAMHSA Administrator, Lisa Halpern, Program Director of the Dorchester Bay Recovery Center, Rodger McDaniel, Executive Director, Wyoming Mental Health and Substance Abuse Services Division, and Terry Lee Allebaugh, Executive Director, Housing for New Hope, Inc.

During today's hearing, I hope we can gain a better understanding of SAMHSA's role and needs as well as have an opportunity to discuss recommendations for the committee as we begin the SAMHSA reauthorization process.

I look forward to the testimony of our witnesses and thank you all again for being here this morning.

OPENING STATEMENT OF SENATOR ENZI

Senator ENZI. Thank you, Mr. Chairman, and I want to thank you and Senator Kennedy for holding this important hearing today. I want to thank the witnesses for taking their valuable time to come and share their ideas with us, and then hopefully to answer some questions, and then even have some follow up written questions, probably, and usually get into a lot more detail.

I want to particularly thank my friend Rodger McDaniel for traveling here from Wyoming to represent the Wyoming Department of Health, glad to have you here.

I'm pleased to be working in a bipartisan fashion to reauthorize the Substance Abuse and Mental Health Services Administration, known as SAMHSA. Congress established SAMHSA to strengthen the Nation's healthcare delivery system with regard to the prevention and treatment of mental illness and substance abuse and also to provide emergency disaster assistance and to combat homelessness.

The issues we face in the reauthorization of SAMHSA are among the most important issues Congress can address, that is, the health and well-being of our citizens. I'm gratified that we've come a long way in addressing these problems through the many successes of SAMHSA, in recognizing that mental health and substance abuse are illnesses that are treatable. The committee needs to assess SAMHSA's operation, and make changes to ensure that it's operating at the highest possible level of efficiency. It currently measures outcomes, and that will be a great benefit as we work through reauthorization.

As many of my colleagues are aware, today's system of services of mental health, substance abuse and homelessness is fragmented and disconnected. These challenges will be addressed in the reauthorization process. States and local communities can provide the best approach to prevention and treatment, because they're on the front lines, and in the best position to develop creative solutions.

I'm also interested in evaluating the flexibility of the grant programs, as well as accountability measures. We need to ensure that scarce Federal dollars are focused where the greatest need exists.

In the light of recent tragedies like Hurricane Katrina, and Rita, and the events at Virginia Tech last month, it's important, that we review the role of SAMHSA in disaster and emergency response. SAMHSA serves a key role in events like these, so flexibility in the use of these funds is key to ensuring that the programs can adapt to changing needs, or target specific situations.

I must also mention the epidemic of methamphetamine, or meth, in the United States. Statistics show that approximately 5 percent of the population in the United States is addicted to it. Meth is a highly addictive drug, and easily produced in clandestine laboratories with inexpensive, over-the-counter products. Wyoming is among the top third of States with persons age 12 or older using meth.

Wyoming students have been hit hard. Drug-related arrests have doubled in Wyoming, with meth playing a large role in the rising rate in crime, domestic violence, and poor health. Rural communities and Native Americans have been especially hard hit. Eradication of this epidemic is in our grasp, and I hope to explore SAMHSA's role in this critical effort. Fixing this problem will require both short- and long-term strategies.

Again, I want to thank the witnesses for their participation in today's hearing, and I look forward to the testimony.

Senator REED. Thank you very much, Senator Enzi.

And now, it's my pleasure to introduce my colleague, and my friend from Rhode Island, Congressman Patrick Kennedy. Patrick is in his seventh term, serving the people of the First District of Rhode Island. He is a member of the Appropriations Committee, and has been a tireless advocate for important projects to my State and also for those issues affecting the mental health of the entire country. He has demonstrated over his tenure in the U.S. Congress the commitment and the passion to help people, particularly those who are struggling with the issues of mental health and substance abuse.

We have your written testimony, Congressman, your excellent written testimony, and feel free to summarize, and welcome today to the committee.

STATEMENT OF REPRESENTATIVE KENNEDY

Representative KENNEDY. Thank you very much, Senator Reed, and Senator Enzi. Thank you very much for inviting me to testify.

I particularly want to thank Senator Reed for inviting me and appreciate your being the committee chairman today. I'm proud to have a fellow Rhode Islander holding the gavel today. Although I'm very fond of the committee chairman who's usually at the gavel——

[Laughter.]

I'm very proud that you're, today, holding the gavel.

And I want to thank Senator Enzi for his leadership on the parity legislation in the Senate and look forward to working with him on an opportunity to pass historic legislation in the Congress this year to provide mental health parity in this country for all Ameri-

cans who are, right now, discriminated against in their mental health insurance coverage.

When you get right down to it, we really do a terrible job in this country—as you pointed out, Senator Enzi—of delivering mental health and substance abuse care in this Country. Because, as you pointed out, it's often fragmented, and we do a very poor job, it's little to do with SAMHSA's people, because they're very dedicated, and they're swimming upstream in a culture and a Government that undervalues mental health and substance abuse treatment, very simply because, the fact is, of the stigma. And those that don't get the benefit from the latest science.

So, what I would like to recommend today, is that we—Congress—in reauthorizing SAMHSA, should ensure that the Agency be a force for transforming this fragmented and broken mental health and substance abuse treatment system of ours, by bringing this segregated, entirely divorced from the rest of the healthcare system, mental health and substance abuse and integrating it into the overall, primary healthcare system that we have.

And I—with that perspective in mind, I suggest three overarching themes for our focus: driving the development and use of evidence base in the delivery of mental health and substance abuse treatment, dramatically improving the coordination of mental health and substance abuse and primary care, and expanding our investment in prevention.

These are the dynamics that will help in making sure that SAMHSA acts as the lever of change in acting as a real catalyst for making the overall system work to the advantage for everybody.

I've elaborated in my testimony on several specific ideas for reauthorization, but as Senator Reed pointed out, I'll really get into a few specific examples.

The permanent Commission for Evidence-Based Mental Health and Substance-Use Health Care. This goes to the evidence-based part that I spoke of. This would be an expert, nonpolitical panel that would be responsible for strengthening, consolidating, coordinating, and synthesizing the dissemination of evidence-based practices.

As you know, Senator Enzi, the big criticism of us bringing parity into mental health care, as people say, "Well, we want to make sure we get what we pay for." Well, we ought to be getting what we pay for in regular health care, and frankly, the evidence shows us that we barely get 50/50 evidence-based medicine in normal health care in our system, forget mental health care.

But, the fact is, when we do get parity, we ought to get the evidence-based, and that's why we should set up a Commission to make sure that whenever there's delivery of substance abuse and mental health services, that it is the latest and best knowledge in how to deliver those services.

By benchmarking this evidence-based practice, and giving them the Good Housekeeping Seal of Approval, this Commission could provide the guidance to the whole entire field, as well as the training and professional development, so that anybody in this country going to get the treatment that they need could be sure that they are getting the latest and best of that treatment. It also would help us establish priorities in areas of future research.

Also, just last week, USAToday ran a front-page story on a new report that individuals in the public mental health system die, on average, 25 years earlier than the general population, as Senator Reed mentioned in his opening remarks. This is not just based on suicide, but poorly-managed general health care, and chronic illnesses like diabetes and heart disease.

And, improving the coordination amongst mental health, substance abuse and primary care is the key to this. If you treat someone with mental illness, you also help cut down on the costs of someone, treating someone with diabetes and other chronic illnesses. That's why integrating the care of mental illness, along with primary care and substance abuse is so crucial.

So, without opening the doors to merging block grants, I would propose that we use block grants to allow providers to do a better job to deliver the most effective, integrated care to individuals who have co-occurring disorders. Right now, substance abuse is delivered through one block grant, mental health is delivered through another block grant—we need to point out, that as Senator Reed mentioned, so many of substance abuse disorders and mental health disorders are often co-occurring disorders. But you can't expect someone to get substance abuse treatment here, and mental health treatment across town. You have to allow more flexibility for a substance abuse provider to treat not only the substance abuse problem, but the mental health problem, and the mental health provider to do the same for the person with the mental illness, but who's also suffering from a substance abuse problem.

There's got to be greater flexibility in dollars. Right now those dollars are dis-apportioned. We need to look at the way those dollars are apportioned, and make sure they go to where they are best suited to treat the people who are most in need, as you pointed out, Senator Enzi, where they're greatest in need, and I would recommend that.

And finally, establish an ongoing inter-agency mental health working group to collaborate around these issues, so that we can continue to meet the consumers' needs, in making sure that we have this ending of the disconnect between the barriers between substance abuse and the mental health base that currently exists.

Finally, prevention needs to be at the cornerstone of any future reauthorization, and prevention means school-based behavioral health, and it also means making sure that we do a better job at preventing. And, by preventing, we know that if we reach a family that's at high risk—if a child comes from a family where the parents have substance abuse problems themselves, where the parents are in jail, where the parents have domestic violence, where the parents are in severe poverty—you know if those children come from those four characteristics of a family, those children are umpteen times more likely to have special education problems, substance abuse problems, alcohol problems, and criminal justice problems down the road. It's just shown by the social science evidence.

So, you don't have to provide intervention for all families, we don't have the budgets for it, but you do have to provide interventions for those high-risk groups, and so what I would propose is that we really focus on making sure that we adequately fund the Starting Early, Starting Smart program, which was a pilot pro-

gram in the last SAMHSA reauthorization, and it focuses on at-risk families. Because you can't reach the kids until you reach the parents, and this is really a program that reaches the parents who are at highest risk, and that's the best way to reach the kids, is to reach the mother and father who are at highest risk.

And, with that, Mr. Chairman, I appreciate the time.

[The prepared statement of Representative Kennedy follows:]

PREPARED STATEMENT OF REPRESENTATIVE KENNEDY

Senator Reed and Senator Enzi, thank you for inviting me to testify today. Senator Reed, I'd like to particularly commend you on your leadership in this hearing. While I'm very fond of the committee chairman, I'm also proud to have a fellow Rhode Islander holding the gavel today, and exhibiting a strong voice for improving mental health and substance abuse care every day.

When you get right down to it, we do a terrible job delivering mental health and substance abuse care in this country. This is not a knock on the providers, who are for the most part paid a pittance and are truly doing the Lord's work with little thanks. It's also not a knock on SAMHSA. The people there are dedicated and swimming hard upstream in a culture and government that undervalues mental health and substance abuse treatment, trying to improve care and create change.

The fact is, however, most people in need of treatment don't get it. Those who do often don't get the benefit of the latest science. Care for mental illnesses and substance abuse is segregated, often nearly entirely divorced from the rest of health care and even from each other.

Every few years, it seems, there's another blue ribbon report on the challenges we face on mental health and substance abuse. The Surgeon General's report in 1999. The New Freedom Commission report in 2003. The Institute of Medicine report in 2005. The focuses of these reports differ, but the underlying message of all are consistent: in the words of the New Freedom Commission, "the mental health services system does *not* adequately serve millions of people who need care."[1]

Congress's goal for reauthorizing SAMHSA should be to ensure that the agency can be a force for transforming our fragmented and broken mental health and substance abuse treatment systems. We need to be thinking systemically, and asking what levers we can pull that will change the underlying dynamics of the mental health and substance abuse systems.

With that perspective in mind, I would suggest three overarching themes for our focus: (1) driving the development and use of the evidence base; (2) dramatically improving the coordination of mental health, substance abuse, and primary care; and (3) expanding our investment in prevention.

DEVELOPING AND USING THE EVIDENCE BASE

There are several interrelated problems when it comes to the evidence base. At a systems level, we remain set up to deliver care

[1] President's New Freedom Commission on Mental Health, *Interim Report to the President* (2002), p. 1.

that is more expensive, inpatient-oriented, and in response to crises rather than a community- and family-based, recovery-oriented model of service delivery. We know that doesn't produce the best outcomes and certainly is not a good use of scarce resources, yet we inhibit the evidence-based approach to care delivery.

Another problem is that far too often providers don't use the science we have. The IOM's report on Improving the Quality of Health Care for Mental Health and Substance-Use Disorders, a number of studies have documented the failure of clinicians to adhere to evidence-based care guidelines for a wide range of disorders. Overall, in only 27 percent of studies were adequate adherence rates found.[2]

A third problem is that the research is often not directly relevant to real-world practice. Participants in trials are often screened out to ensure they don't have co-occurring disorders or other complicating factors, and most trials take place in academic medical centers, not at the community based treatment centers where so much care actually occurs. As in the rest of health care, we invest very little in comparative outcomes research and services research, to discover which interventions are more cost-effective, and how to most effectively and safely deliver care.

While the solutions to these problems go beyond SAMHSA, there are some important steps we can take to build the development and use of the evidence base into our mental health and substance abuse treatment systems.

First, we need to support SAMHSA's efforts in recent years to help States transform antiquated systems. For years we have known that community-based systems of care produce better outcomes at a fraction of the cost of institution-based systems. In Rhode Island in 2000, a year in residential treatment for an adolescent cost $242,000, a year in the Training School cost $94,000, and a year of intensive, community-based services cost $14,000.[3] SAMHSA made a few rounds of transformation grants to help States move to a more modern approach, but has been unable to implement those fully as the budget has been squeezed. The problem in many States is that the transition cannot happen all at once. Creating new treatment options carries a cost, but does not allow the State to immediately stop paying for beds it is carrying. We need to figure out ways for SAMHSA to support the transition, while ensuring that the funds carry accountability for changes to evidence-based systems of care.

On a related note, we should expect more of States that have received Children's System of Care grants. These grants have produced islands of excellence in local communities, but are too often not sustained and not brought to scale. The program has been highly successful, but should be tweaked to ensure greater involvement and buy-in from the State and incentives to replicate local successes in other communities and statewide.

Next, I propose the creation of a permanent Commission for Evidence-Based Mental Health and Substance-Use Health Care. This

[2] Institute of Medicine, *Improving the Quality of Health Care for Mental Health and Substance-Use Disorders* (2005), p. 133.

[3] Rhode Island Public Expenditure Council, *A Review of the Department of Children, Youth and Families* (2001), p. 32.

expert panel would be responsible for strengthening, consolidating, and coordinating the synthesis and dissemination of evidence-based best practices.

This non-political commission would build on work being done at SAMHSA, as well as at AHRQ and NIH. The Commission would be able to provide a "good housekeeping seal of approval" to prevention, screening, diagnosis, and treatment practices supported by science and to create a research agenda by identifying areas where strong evidence is lacking.

By benchmarking evidence-based practices, the Commission could provide guidance to the field to focus training and professional development. It would also allow for the development of performance measures that can, over time, enable pay-for-performance and other value-based purchasing strategies that are the most important means of improving care. Because the research base is thin in many areas, we need to be very careful not to go too far too quickly in linking payment to the use of evidence-based practices—we do not want to shut down access to effective interventions that may not have been adequately researched yet. But ultimately, payment drives practice patterns, and if we want to better use the evidence base and get better outcomes and a more efficient use of resources, we need to adjust how we pay for care.

A complement to payment-based strategies for improving the quality of care is better direction by the professions themselves. This field is marked by a large number of different professions, with a wide range in terms of training, credentialing, and licensure. There is little consistency or quality control across mental health and substance abuse treatment.

We should heed the Institute of Medicine's recommendation to create a Council on the Mental Health and Substance-Use Workforce, to parallel councils for physicians and nurses. This new council would provide guidance to graduate schools and State licensing bodies to ensure that professionals working in the field have appropriate expertise grounded in the latest science and that consumers have meaningful information about providers when seeking out care. This group could also provide an ongoing assessment and data to back up the widespread anecdotal reports of critical workforce shortages in the field.

Finally—and this may be a bit further afield for a SAMHSA reauthorization bill—I believe we need to create a national network of mental health and substance abuse centers of excellence, akin to the national centers of excellence in cancer. We need to tie our cutting edge, institution-based research to community-based practice settings, and make a national commitment to finding new cures and treatments. While there's been an explosion in understanding of these diseases due to brain scanning technology and genomics, we are still essentially using variations on the same treatments we had 30 years ago. I would like to see a major initiative that can dramatically expand the evidence base, building on and tying together the work that is happening at leading institutions like Brown, the University of Michigan, UCLA, and UC-Davis. I have spoken to leading researchers around the country and believe that the time is right for a national network that could be greater than the sum of its parts.

DRAMATICALLY IMPROVING THE COORDINATION OF CARE

Just last week USA Today ran a front page story on a new report that shows that individuals in the public mental health system die, on average, 25 years earlier than the general population.[4] This shocking outcome is not based on suicide, mind you, but on poorly managed general health and other chronic diseases like diabetes and heart disease.

Part of the explanation may lie in the comorbidity of mental illnesses and smoking or the side-effects of medications commonly taken by people with mental illnesses. Undoubtedly, however, a major contributor is the poor coordination between primary health care and mental health and substance abuse care. The problem is severe even within behavioral health, as mental health and substance abuse care are often siloed, even though the patients are so often the same people.

The Federal Government bears a chunk of the responsibility, and one thing we should seek to do with this reauthorization is to take down some of the barriers that we erect between primary care, mental health care, and substance abuse care.

I am well aware of the historical factors at play in this space, and that even talking about better integrating mental health and substance abuse treatment makes some people's hair stand up on end. But I am also aware that research unambiguously shows that individuals' outcomes are better when care is coordinated and, ideally, integrated. And I believe that there are steps we can take that would help without upending our current patterns.

For example, it is currently very difficult to use either mental health or substance abuse treatment block grant funds to pay for truly integrated care for co-occurring disorders. That's because the block grants carry strict requirements on paying only for mental health or substance abuse respectively, so documentation problems arise when the care is integrated. Without opening the door to merging the block grants, it should be possible to enable providers—or even better, to encourage them—to deliver the most effective, integrated care to individuals with co-occurring disorders.

Similarly, I would like to see ways of encouraging our community behavioral health centers and community health centers to collaborate. We spend enormous sums on two parallel systems of community health providers. But because one is funded out of HRSA and the other out of SAMHSA, their collaboration is haphazard at best. Imagine if instead centers were co-located. Or even that whenever a person contacted a community behavioral health center for an appointment, they were also given an appointment at the community health center to check their other chronic diseases. We should build incentives into these funding streams to bring about partnerships that will bring people's care together.

Of course, these kinds of disconnects exist throughout various government programs. The Federal Government should get its own house in order, and begin collaborating around mental health and substance abuse, so it can ensure that collaboration occurs where services actually meet consumers.

[4] Marilyn Elias, "Mentally Ill Die 25 Years Earlier, on Average." *USA Today* (May 3, 2007).

One such success story is the Safe Schools Healthy Students program (SSHS). In 2001, then-Surgeon General David Satcher came to Rhode Island for a forum I put together on children's mental health. Surgeon General Satcher singled out SSHS as the most successful program he had seen in mental health. Now remember, this is just a year after his groundbreaking mental health report. What distinguished SSHS, he said, was that it was a genuine partnership between SAMHSA, the Department of Justice, and the Department of Education, and their counterparts at the local level. Because the three Federal departments developed and funded the program together (at least in the early years), it was able to require and get real buy-in from the police departments, schools, and mental health agencies and was therefore extremely effective.

SSHS should be a model for us. We should create an ongoing behavioral health working group among various HHS agencies, VA, DOD, DOJ, Education, and perhaps even HUD and Labor. The mandate of this group should be to ensure that programs for mental health and substance abuse treatment do not conflict with each other and to foster collaboration in the delivery of services. We should ensure that the agencies have authority to pool their funds for interagency grants like SSHS was initially. Until our own Federal Government gets its house in order, we cannot realistically expect our systems to regularly deliver the kind of coordinated care consumers need and deserve.

EXPANDING OUR INVESTMENT IN PREVENTION

With so much unmet need for treatment, it is difficult to carve out funding for prevention. Still, we all appreciate how frustrating, absurd, and inefficient it is to be waiting for people to crash when we have some ideas about how to keep them healthy in the first place.

I would begin with a much more robust investment in the most vulnerable children from birth to six. The fact is, we know which children are most likely to be abusing drugs and alcohol or wind up with mental health problems when they are older. We know them by behaviors—just ask any kindergarten teacher which students are heading for trouble—and we know them by environmental factors. The research clearly shows that kids living in homes with maternal depression, substance abuse, and family violence are much, much more prone to developing problems of their own. There are actual, physical changes to their brains that occur as a result of the toxic stress levels that they are subjected to.

We also know how to have the greatest impact on those children and set them on more healthy trajectory: work with the family. There's some fascinating research out of the NYU Child Study Center's Parent Corps program. They worked with the parents only, no intervention with the children. After intensive lessons and guidance in parenting and such things as discipline, dealing with crying babies, and the like, the program produced measurable changes in the children's brains—physiological changes in the children as a result of working solely with the parents. And we know from studies like the Perry Preschool Study that intervening early can change outcomes for life. For example, at age 40, participants in that study were 50 percent more likely than their counterparts to be earning

$20,000 per year, 44 percent more likely to have graduated high school, and 53 percent less likely to have been arrested five or more times. The investment in these young children's lives has thereby paid off annualized internal rate of return of 18 percent in additional tax revenues and expenditures saved.[5]

The Starting Early Starting Smart program, an innovative joint venture of the Casey Foundation and the Center for Substance Abuse Prevention at SAMHSA, was a family- and caregiver-focused approach to working with vulnerable children, using child care providers and pediatricians as the entry point. Unfortunately, it was conducted as a research demo, and allowed to peter out. We should resurrect that approach. SAMHSA's commitment to prevention should include a significant investment in young children with multiple risk factors and in their families.

We also should bring a stronger prevention ethos to school-based behavioral health. Approaches based on positive behavioral supports that help improve all students, provide early identification for students in need of formal assessments, and services along a continuum can prevent students from falling through cracks and reaching crises before their needs are recognized or met. In partnership with the Department of Education, SAMHSA should work to broaden the role of school-based mental health personnel as well as expand collaborative programs such as SSHS.

CONCLUSION

There is no shortage of priorities in the mental health and substance abuse fields. In addition to the issues discussed above, there are plenty of other things that should happen in a reauthorization of SAMHSA: fostering the use of information technology and ensuring that the mental health and substance abuse field is integrated into the larger health IT systems being developed; reauthorizing the Garrett Lee Smith Act; codifying a program to focus on the mental health and substance abuse treatment needs of seniors; authorizing the Keeping Families Together Act; and developing performance measures at both the systems and provider levels are just some of the priorities that should be included.

That said, we also must acknowledge the two major limitations on this bill: first that Medicaid, much more than SAMHSA, is driving the direction of the mental health system today (and currently, in the wrong direction, away from a recovery model), and secondly, that SAMHSA is and will continue to be for the foreseeable future woefully underfunded.

Given those two realities, I believe we really must think strategically about how we use SAMHSA's resources. While there are many terrific grant programs, a number of which I strongly advocate for in the Appropriations Committee every year, the fact is that with its limitations, SAMHSA is much better off leveraging systems change than funding services. As we move forward, I would urge the committee to think carefully about how a reauthorized SAMHSA can put in place infrastructure, systems, and incen-

[5] Lawrence J. Schweinhart, Ph.D., *The High/Scope Perry Preschool Study Through Age 40: Summary, Conclusions, and Frequently Asked Questions* (2005).

tives that will drive long-term, lasting change in the way care is delivered.

Thank you for the privilege of testifying today. I look forward to working with you to bring more accessible, higher quality, and more efficient mental health and substance abuse care to all Americans. Thank you.

Senator REED. Thank you very much, Congressman, for your insightful testimony. And your framework of evidence-based legislation, coordination of primary care and prevention is a good place for us to begin, and I thank you. I know you'll be working hard in the other body, where we both served, to ensure that this authorization proceeds forward.

We've been joined by Senators Burr, Murkowski and Senator Murray, and I would—if they had questions or comments, I'd invite them at this time.

Thank you very much, Congressman.

Representative KENNEDY. Thank you.

Senator REED. Now, I'd like to call forward for the second panel, Dr. Terry Cline, the Administrator of the Substance Abuse and Mental Health Services Administration.

Dr. Cline was nominated by President George W. Bush, on November 13, 2006, and confirmed on December 9, 2006, as the Administrator for the Substance Abuse and Mental Health Services Administration. As a SAMHSA Administrator, Dr. Cline leads an agency with a $3.3 billion budget, and is responsible for improving the accountability, capacity, and effectiveness of the Nation's substance abuse prevention, addictions treatment, and mental health service delivery systems.

Prior to his appointment, Dr. Cline served as Oklahoma's Secretary of Health, a position he was appointed to by Governor Brad Henry in 2004. At the same time, he served as Oklahoma's Commissioner of the Department of Mental Health and Substance Abuse Services, a position he held since January 2001.

Dr. Cline also has extensive clinical experience, he was a Clinical Director of the Cambridge Youth Guidance Center in Cambridge, Massachusetts, and a staff psychologist at McLean Hospital in Belmont, Massachusetts.

His professional history also includes a 6-year appointment as a clinical instructor in the Department of Psychiatry at Harvard Medical School, and Chairman of the Governing Board for Harvard Teaching Hospital in Cambridge, Massachusetts. A native of Ardmore, Oklahoma, Dr. Cline attended the University of Oklahoma where he earned a Bachelor Degree in psychology in 1980, and then received both a Master's degree and a Doctorate in Clinical Psychology from the Oklahoma State University.

Dr. Cline has involved himself in community service at the local, State and National levels, it is a pleasure to welcome him here today. Dr. Cline, thank you.

STATEMENT OF TERRY CLINE, PH.D, ADMINISTRATOR, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, ROCKVILLE, MARYLAND

Mr. CLINE. Thank you very much, Mr. Chairman, members of the committee. I appreciate the opportunity to present to you today, and to talk about SAMHSA's vision and mission.

I came to SAMHSA in my position in January with a very clear understanding of the importance of SAMHSA's vision and mission. As an undergraduate, I had worked my way through college by working on an inpatient children's unit, where we served young kids, as young as 5 years old.

I returned as a student several years later, to that very same hospital, and saw some of the same children still living in that institution. Some of those children hundreds of miles away from their families.

As a clinician in Cambridge, I provided home-based family therapy to low-income housing developments, and every time I went to visit one family, I would walk by dozens of other families that were in need of services, but were not able to receive those services, because I was only serving one family at a time. So that need was very, very great.

And then as Commissioner in Oklahoma, and as the Secretary of Health, I was able to see that ripple effect across our entire State system, to see the repercussions, what happens when we are not able to meet the needs of people who are struggling with mental illness, and who are struggling with their addictions, across both the private and the public sectors of the entire State system, very dramatic.

Recently, we saw the results of a report from the Agency for Health Care Research and Quality, which highlighted the finding that a quarter of all hospital stays in the country—about 7.6 million of the overall 32 million hospital stays—involve people with the diagnosis of mental illness or substance abuse. This tells us that that ripple is effecting people being seen in general hospital settings, rather than being seen in more specialty services.

We also know when we don't provide those services, that there is a human cost, as well as that economic cost—sometimes there are lost jobs, sometimes lost families, sometimes lost lives. There are approximately 30,000 individuals who commit suicide every single year in the United States of America. I come from a small town of about 25,000 people, in Oklahoma, so I try to imagine the entire population of that town being lost—not just 1 year, but year after year after year—30,000 people every year, lost to suicide.

So, even in the midst of all of these struggles and all of these challenges, there is good news. And the good news is that people can, and people do recover from mental illness, people can and do recover from substance abuse and addiction. There are evidence-based practices for treatment, and there are effective strategies for prevention.

And, as an example in prevention, we know that in 2006, approximately 840,000 youth—fewer youth—are using drugs in 2006 than were using in 2001. So, we're able to reach those young populations and to prevent them from using drugs.

As we address these challenges and move toward a vision, SAMHSA has embarked on a strategic plan that includes accountability, capacity, and effectiveness of services, really, the three legs of a stool in our strategic plan.

In our partnership with stakeholders across the country, we have developed national outcomes measures which reflect real-life meaningful outcomes for people who are striving to attain, and sustain, recovery in their lives. These are individuals who are holding jobs, these are individuals who are living with their families, these are individuals that are able to participate fully in their communities of choice, and again this is done in partnership with stakeholders across the country.

We also know, and we heard this reflected earlier in the testimony from Representative Kennedy, that to better serve these particular populations, we know that we need to completely transform our behavioral health systems. The President's new Freedom Commission on Mental Health found that we have an incredibly fragmented, fractured system, which is not effectively serving people in need in our country.

I believe a public health approach which provides comprehensive services, and an entire range of services, including prevention, early intervention, acute treatment and recovery support services, is the approach that will best serve the people of our country. We've seen this work for other illness categories, and we know it will work here, as well.

I believe that as we strive to address the needs of people with mental illness, and people who are struggling with addictions and chemical dependency, that we will be a much stronger country, and a healthier Nation.

I look forward to working with you as the year progresses, and I again, appreciate this opportunity to present to you today. And, I'd be happy to answer any questions you may have.

[The prepared statement of Dr. Cline follows:]

PREPARED STATEMENT OF TERRY L. CLINE, PH.D.

Mr. Chairman and members of the committee, I am honored to present to you the vision, mission, and priorities of the Substance Abuse and Mental Health Services Administration (SAMHSA), an agency of the Department of Health and Human Services (HHS).

SAMHSA has established a clear vision for its work—a life in the community for everyone. To realize this vision, the Agency has sharply focused its mission on building resilience and facilitating recovery for people with or at risk for mental or substance use disorders. To achieve its vision and mission, SAMHSA directs a rich portfolio of grant programs and contracts that support State and community efforts to increase accountability, build capacity, and improve the effectiveness of substance abuse and mental health service delivery systems.

The need for SAMHSA's strategic focus on strengthening service delivery systems is undeniable. There are economic costs of undiagnosed and untreated mental and substance use disorders. There are also human costs—measured in lost jobs, lost families and lost lives—that are incalculable and affect the well-being of millions of Americans. SAMHSA, through its offices and centers—the Center for Substance Abuse Prevention (CSAP), the Center for Substance Abuse Treatment (CSAT), and the Center for Mental Health Services (CMHS)—is working with State and local governments, tribal organizations, consumers, families, service providers, professional organizations, and the Administration to focus National attention and resources on prevention, treatment and recovery support services.

Without prevention, treatment and recovery support services, data confirm the enormous role that substance use and mental health disorders play in increasing our Nation's health care costs. For example, according to a new report by HHS'

Agency for Healthcare Research and Quality, almost one-fourth of all stays in U.S.-community hospitals for patients age 18 and older in 2004—7.6 million of nearly 32 million stays—involved depressive, bipolar, schizophrenia and other mental health disorders or substance use related disorders. This study presents the first documentation of the full impact of mental and substance use disorders on U.S.-community hospitals.

The significant number of hospital stays related to mental and substance use disorders signals the need to identify and intervene early before the conditions require a hospital stay. Too often because of social stigma or lack of understanding, individuals and health care providers do not recognize the signs or treat mental or substance use disorders with the same urgency as other medical conditions. For example, the full spectrum of substance use disorders can be identified by screening tools which can result in an intervention. The Administration is working to meet this need through the Screening, Brief Intervention, Referral and Treatment (SBIRT) program funded by SAMHSA. This program uses cooperative agreements to expand and enhance a State or tribal organization's continuum of prevention, intervention, and treatment by adding screening, brief intervention, referral, and treatment services within general medical settings.

Also to be considered is the component of mental and substance use disorders that patients themselves often do not recognize or understand. For example, in 2005 the number of persons 12 and older who needed treatment for an alcohol or drug use problem was 23.2 million, according to SAMHSA's National Survey on Drug Use and Health. Of these, 2.3 million received treatment at a specialty facility. Specialty treatment is defined as treatment received at any of the following types of facilities: hospitals (inpatient only), drug or alcohol rehabilitation facilities (inpatient or outpatient), or mental health centers. The survey also points to a huge denial gap. Among individuals with drug or alcohol dependence or abuse who have not received treatment, more than 94 percent do not feel they need treatment.

Unlike an obvious broken bone, burn, laceration, or other physical wound, addiction and mental illnesses often do not have outward physical signs. Adding another layer to the complexity of seeking timely and appropriate treatment is the barrier of not knowing when or where to seek help and the lack of awareness that mental and substance use disorders often co-occur. Beyond these barriers, the issues of stigma, access, and availability of services also present roadblocks to early intervention, treatment, and recovery.

Yet SAMHSA—knowing the barriers, accepting the challenges, and fully understanding the importance of our role in the pubic health approach to creating a healthier America—continues to move forward working to improve and save lives that otherwise might be lost to devastating symptoms, isolation and even suicide. SAMHSA moves forward with the understanding that recovery is the expected outcome, by identifying areas of greatest need through data collection, filling those needs through evidence-based service delivery, and then measuring effectiveness and managing agency resources through an informed data strategy and recovery-based outcome measures.

RECOVERY IS THE EXPECTED OUTCOME WITH THE PUBLIC HEALTH APPROACH

With appropriate help, individuals with mental illnesses, substance use disorders, and co-occurring disorders can and do recover. These conditions are chronic illnesses; relapses are possible; and the recovery process can be protracted. However, when these individuals take that brave step toward seeking help, and the right services and treatment take hold, the potential for recovery can unfold. Today, recovery is no longer the exception; it is the expectation. To advance the recovery paradigm the public health approach is required, working with people in the context of their environments. The public health model uses systems that provide a continuum of services that focus on an entire population rather than on individuals with individual illnesses. The continuum begins with an assessment of need and ends with a population-based, evaluated approach that extends into practice, research, policy, and the engagement of the public itself.

DATA COLLECTION TO DEFINE NEEDS

SAMHSA reports to the Nation on the prevalence of substance use and mental health problems in the United States. One of those measures is provided by our National Survey on Drug Use and Health. The survey provides national and comparable State-level estimates of substance use, abuse, and dependence. It also provides an ongoing source of nationally representative and State-level information on mental health.

The analysis of trends over time from the survey, alone and in combination with other data sources, provides an invaluable tool to measure outcomes of the National Drug Control Strategy and to report our progress to Congress. Two other major national surveys conducted by SAMHSA include the Drug Abuse Warning Network (DAWN) and the Drug and Alcohol Services Information System (DASIS). The DAWN obtains information on drug-related admissions to emergency departments and drug-related deaths identified by medical examiners. DASIS consists of three data sets developed with State governments. These data collection efforts provide national and State information on the substance abuse treatment system.

EXPANDING SUBSTANCE ABUSE TREATMENT CAPACITY

The cornerstone of the Nation's substance abuse prevention and treatment activities is the Substance Abuse Prevention and Treatment Block Grant funded by SAMHSA which is designed to support and expand substance abuse prevention and treatment services, while providing maximum flexibility to States. It provides support to 60 eligible States, territories, the District of Columbia and the Red Lake Indian Tribe. SAMHSA's CSAT also funds an array of discretionary grants through the Programs of Regional and National Significance to build treatment capacity, including innovative financing (e.g., Access to Recovery Program) and increased use of screening, brief interventions, referral and treatment services.

SAMHSA has partnered with health care professionals to expand use of screening and brief interventions to identify the full spectrum of substance users as a routine part of standard health care and provide brief, cost-effective interventions to help them cease substance use once discovered. The modality, called Screening, Brief Intervention, Referral and Treatment (SBIRT), has been deployed to hospitals, health clinics, college campuses and school-based clinics across the country. Under SBIRT, medical professionals conduct brief screening in a general health care setting such as a hospital, a health clinic or a university-based clinic. Under SBIRT, once a problem is detected, a medical professional immediately performs a brief intervention, lasting less than 30 minutes. Brief interventions assist patients in recognizing the impact of unhealthy drinking or drug use and commit them to a plan of action to cease use. Studies show that this brief intervention can reduce substance abuse significantly, thus improving overall health. These interventions are very cost-effective as they reduce re-admission into emergency departments and rehospitalizations. In many cases, the brief intervention is sufficient for the non-addicted user. Those with scores that fall into the range of dependence are referred to more intensive treatment.

To date the Federal SBIRT program has screened 504,334 people in healthcare settings in 10 States in the Nation. A positive screen was obtained in 21.2 percent of people screened, and these were subsequently provided with brief intervention (15.1 percent), brief treatment (2.7 percent), or were referred to treatment (3.3 percent). Six-month follow ups on a sampling of those receiving an intervention show promising reductions in substance use, depression and improvements in other parameters.

For those referred to treatment because they have become addicted, SAMHSA has expanded options for treatment. The Access to Recovery (ATR) program, a Presidential initiative, is a key source of innovation in the field of addiction recovery. Through the use of vouchers, ATR provides clients with the opportunity to choose among a broad array of substance abuse clinical treatment and recovery support service providers. ATR is designed to: (1) allow recovery to be pursued through personal choice and many pathways; (2) require grantees to manage performance-based outcomes that demonstrate client successes, (3) expand capacity by increasing the number and types of providers who deliver clinical treatment and/or recovery support services. The outcomes for clients served through the ATR program are very encouraging. As of December 31, 2006, the ATR program had served 137,579 clients, exceeding the initial target by 10 percent. After receiving services through ATR, 81 percent of clients are abstinent from substances and 51 percent are in stable housing.

Expanding substance abuse treatment capacity also has a direct link to shrinking rates of criminal recidivism. Upon discharge from the ATR program, 97 percent of clients have no involvement with the criminal justice system. This impressive rate reflects an 81 percent reduction among those who were involved with the criminal justice system at intake. Additionally, drug treatment courts provide a successful alternative to incarceration and help to break the cycle of addiction, crime, incarceration, release, relapse, and recidivism. These courts enable stakeholders to work together to give individual clients the opportunity to improve their lives, including recovering from substance use disorders and developing the capacity and skills to be-

come full-functioning parents, employees, and citizens. Close supervision, drug testing, and the use of sanctions and incentives help to ensure that offenders stick with their treatment plans while public safety needs are met.

Other CSAT Programs of Regional and National Significance (PRNS) include: Targeted Capacity Expansion Grants (TCE-General) which have focused on treatment for methamphetamine use, minority populations, and rural areas, to name a few; Grants to Benefit Homeless Individuals; and the Minority HIV/AIDS and Substance Abuse Treatment Grant program. SAMHSA has focused its grant resources on activities that directly demonstrate improvements in substance abuse outcomes and increase capacity while eliminating less effective or redundant activities within the Substance Abuse Prevention and Treatment PRNS.

STRENGTHENING AND STREAMLINING SUBSTANCE ABUSE PREVENTION EFFORTS

While expanding substance abuse treatment capacity and recovery support services is critical, it is imperative not to lose sight of the importance of preventing addiction in the first place by stopping substance use before it starts. SAMHSA will continue the Strategic Prevention Framework grant program to accomplish the President's goal to reduce youth drug use in America, thereby leading to a healthier populace. By focusing our attention, energy and resources we, as a nation, have made real progress toward reaching the President's goal. The most recent data from the 2006 Monitoring the Future Survey confirms that we have reduced youth drug use by 23 percent by 2006. What this means is approximately 840,000 fewer youth used illicit drugs in 2006 than in 2001. Although our work is far from over, prevention remains key and SAMHSA's Strategic Prevention Framework (SPF) will continue to play an important role in achieving the goals of the President's Healthier US Initiative.

To more effectively and efficiently align and focus our prevention resources, SAMHSA launched the SPF State Incentive Grant Program in fiscal year 2004. It is systematically implementing a risk and protective factor approach to prevention across the Nation. The success of the framework will continue to be determined by, in large part, on the tremendous work that comes from the Office of National Drug Control Policy's (ONDCP) grass-roots community anti-drug coalitions. Along those lines, SAMHSA expects to continue working with ONDCP to support the over 750 grantees funded through the Drug-Free Communities grant program. Moreover, with SAMHSA's State Epidemiological Workgroups, we will target funding to areas of greatest need for various prevention interventions and services. Funding to States, communities and tribal organizations will be data driven.

Additionally, SAMHSA will continue to focus energy and take a leadership role in the prevention of underage drinking. According to the Surgeon General's *Call to Action to Prevent and Reduce Underage Drinking*, alcohol is used by more young people than tobacco or illicit drugs. An estimated 10.8 million young people between the ages of 12 and 20 (28.2 percent of this age group) are current drinkers. Nearly 7.2 million (18.8 percent) are binge drinkers, and 2.3 million (6.0 percent) are heavy drinkers. Each day, more than 10,000 young people under the age of 21 take their first drink. We know that we need to change how America thinks about underage drinking if we are to see a significant reduction in the problem. SAMHSA and HHS' National Institute on Alcohol Abuse and Alcoholism (NIAAA) collaborated with the Office of the Surgeon General to produce the Call to Action, which was released on March 6, 2007. The Call to Action provides a public health approach to stimulate action in all sectors of society to prevent and reduce underage drinking.

SAMHSA's Center for Substance Abuse Prevention supports a range of activities that address the substance abuse prevention needs of community-based populations. For example, CSAP supports over 148 grants that work to expand the capacity of community-level domestic public and private non-profit entities to prevent and reduce the onset of substance abuse and transmission of HIV and hepatitis among minority populations and minority re-entry populations. In addition, CSAP supports a $9.8 million Fetal Alcohol Spectrum Disorders Center for Excellence that identifies best practices and builds on evidence-based prevention for pregnant and postpartum women, assistance for those with developmental disabilities, and support for other populations invested in serving those with, or affected by Fetal Alcohol Spectrum Disorders (FASD). Through subcontracts, the FASD program will implement system-wide prevention approaches through States, tribes, communities and territories that have high FASD incidence and prevalence rates. CSAP also has initiatives targeting Native American Populations and oversees the Federal Drug Free Workplace Program.

IMPLEMENTING THE FEDERAL MENTAL HEALTH ACTION AGENDA

Today, there is unprecedented knowledge enabling people with mental illnesses to live, work, learn, and participate fully in their community. The President's New Freedom Commission on Mental Health found in its 2003 report that the time has come for a fundamental transformation of the Nation's approach to mental health care. It reported that the current system is unintentionally focused on managing the disabilities associated with mental illness rather than promoting recovery, and that this limited approach is due to fragmentation, gaps in care, and uneven quality. These systemic problems frustrate the work of many dedicated staff, and make it much harder for people with mental illness and their families to access needed care.

SAMHSA's Center for Mental Health Services (CMHS) is leading the Federal effort to achieve the vision of a transformed mental health system. Among the tasks are: helping Americans understand that mental health is essential to overall health; reorienting the system toward a consumer-and-family driven system; eliminating disparities; providing appropriate mental heath assessment and referral; delivering excellent mental health care and accelerating research; and utilizing technology to access mental health care and information through electronic health records.

Instead of focusing on a few grants that promote transformation, SAMHSA has worked to ensure that the principles of mental health transformation are present throughout all SAMHSA grant activities including the Community Mental Health Services Block Grant, which continues to support comprehensive, community-based systems of care for adults with serious mental illness and children with serious emotional disturbance. Within the CMHS Programs of Regional and National Significance (PRNS), the Mental Health Transformation State Incentive Grants are supporting States in developing a comprehensive mental health plan and improving their mental health services infrastructures. States receiving awards expand the use of evidence-based practices, use technology to improve access to care, and engage consumers in shaping the system to meet their needs.

A transformed mental health delivery system will have a direct impact on SAMHSA's ability to improve services around suicide prevention, school violence prevention, children's mental health, the transition from homelessness to stable housing, and protecting the rights of individuals with mental illnesses.

Starting with suicide prevention, suicide is a preventable tragedy and is a high-priority status within the agency. The reason for the priority is clear: in the past year, approximately 900,000 youth aged 12–17 during their worst or most recent episode of major depression made a plan to commit suicide, and 712,000 attempted suicide. Currently SAMHSA funds a total of $36 million for suicide prevention, including activities authorized by the Garrett Lee Smith Memorial Act, suicide prevention for the American Indian and Alaska Native youth populations, a Suicide Prevention Resource Center, and a 24-hour national hotline. The hotline is available to all those in suicidal crisis who are seeking help. Individuals seeking help through the hotline are routed to 1 of over 120 crisis centers across the country which creates a nationwide lifeline. Approximately 36,000 calls per month are answered by the hotline and responded to by trained counselors.

In regard to preventing school violence, SAMHSA collaborates with the Departments of Education and Justice through the Safe Schools/Healthy Students (SS/HS) program to support local partnerships that promote healthy childhood development and prevent substance abuse and violence. There is tremendous opportunity in the area of early identification of mental health problems as part of a comprehensive approach to prevention. For example, youths aged 12 to 17 who experienced depression in the past year were twice as likely to take their first drink or use drugs for the first time as those who did not experience depression. Among youths who had not used alcohol before, 29.2 percent of those who experienced depression took their first drink in the past year, compared with 14.5 percent of youths who took their first drink but did not have a major depressive episode. And 16.1 percent of youths who experienced depression and had not previously used illicit drugs began drug use; in contrast, 6.9 percent of youths who did not have a major depressive episode began drug use.

It is clear young people with serious emotional disturbances who receive help for their condition are far more likely to experience success in school and far less likely to enter the juvenile justice system or the institutional care system. The Agency's Children's Mental Health Services grant program develops comprehensive, community-based systems of care for children and adolescents with serious emotional disorders and their families. Of children receiving services under this program last year, nearly 70 percent did not require interaction with law enforcement and nearly 90 percent attended school regularly.

In addition to its system transformation activities, the CMHS PRNS also includes funding for National Child Traumatic Stress Initiative and the Minority HIV/AIDS and Mental Health Programs. Homelessness also continues to be a priority program area for SAMHSA. Approximately one-fifth of homeless individuals also have serious mental illnesses. Individuals with serious mental illnesses are homeless more often and have greater difficulty transitioning from homelessness to stable housing than other people. The Agency continues support for an array of individualized services to this vulnerable population through Projects for Assistance in Transition from Homelessness (PATH) and through SAMHSA's Mental Health and Substance Abuse Programs of Regional and National Significance.

Additionally, individuals with mental illnesses and serious emotional disturbances who reside in treatment facilities are particularly vulnerable to neglect and abuse. In response, SAMHSA provides support for State protection and advocacy systems to protect these individuals from abuse, neglect, and civil rights violations. Approximately 80 percent of substantiated allegations of abuse and neglect that are reported to protection and advocacy systems result in positive change for the client.

MEETING NEEDS THROUGH EVIDENCE-BASED SERVICE DELIVERY

The success of SAMHSA's programs and service delivery systems clearly hinges on collaboration. No single agency can do it all. Without exception, partnerships among private sector and Federal, State and local public sector agencies are key to helping provide people with mental and substance use disorders the opportunity to achieve a fulfilling life in the community.

One of our public partners is the National Institutes of Health (NIH). In brief, the NIH Institutes and Centers, including the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism and the National Institute of Mental Health, develop evidence-based practices through research, and SAMHSA supports implementation of evidence-based practices through grants that support service delivery. This partnership forms the basis of our Federal efforts to ensure the best science is used in our service delivery systems. Working both independently and collaboratively, we are committed to establishing pathways to move research findings into community-based practice and to reducing the Institute of Medicine reported 15–20 year lag between the discovery of more efficacious forms of treatment and their incorporation into routine patient care.

To advance "Science and Service" and to ensure the public, and consumers and providers of mental health and substance abuse services are aware of the latest information, prevention interventions, treatments and recovery support services SAMHSA operates in its Health Information Network. SAMHSA also created and funds the National Registry of Evidence-based Programs and Practices (NREPP). NREPP is a web-based decision support system designed to help States and community-based service providers make informed decisions about interventions they select to prevent and treat mental and substance use disorders. The NREPP system is the culmination of a multi-year process that included input from numerous scientific and health care service experts and the public. It currently provides information on 27 interventions. Two-thirds of these received NIH funds for development and testing.

MEASURING EFFECTIVENESS AND MANAGING RESOURCES THROUGH A DATA STRATEGY AND RECOVERY-BASED OUTCOME MEASURES

Performance measurement and management is a challenging and complex issue. Our goal at SAMHSA is to achieve a performance environment with true accountability focused on a limited number of national outcomes and related national outcome measures. This goal is built on a history of extensive dialogue with our colleagues in State mental health and substance abuse service agencies and, most importantly, the people we serve.

The domains we have identified embody meaningful, real life outcomes for people who are striving to attain and sustain recovery, build resilience, work, learn, live, and participate fully in their communities. In collaboration with the States, we have identified 10 domains as our National Outcome Measures, or NOMs.

The first and foremost domain is abstinence from drug use and alcohol abuse or decreased symptoms of mental illness with improved functioning. Four domains focus on resilience and sustaining recovery: getting and keeping a job or enrolling and staying in school; decreased involvement with the criminal justice system; securing a safe, decent, and stable place to live; and social connectedness to and support from others in the community such as family, friends, co-workers, and classmates. Two domains look directly at the treatment process itself in terms of available services and services provided: increased access to services for both mental and

substance use disorders; and increased retention in services for substance abuse treatment or decreased inpatient hospitalizations for mental health treatment. The final three domains examine the quality of services provided: client perception of care, cost-effectiveness, and use of evidenced-based practices in treatment.

Data for reporting on these measures come from the States. States are supported in their efforts by SAMHSA with infrastructure, technical assistance, and financial support through the new State Outcome Measurement and Management System (SOMMS) Program, which is funded through the set-asides for the mental health and substance abuse block grants.

Among the States reporting data to SAMHSA in the Retention and Perception of Care domains for mental health, the NOMs data demonstrates a low percentage (8 percent) of patients returning to State hospitals 30 days after discharge and a high percentage (71 percent) of consumers of mental health services who reported they were doing better as a direct result of services received. With regard to substance abuse, the NOMs data reported to SAMHSA demonstrates significant success in the abstinence domains for both alcohol and drug use with over 94 percent of reporting States indicating improvements in client abstinence. Similar successes were reported in improved client employment and reduction in arrests. Ultimately, SAMHSA will be able to report State-level, consistent, cross-year data which will allow us to examine the impact of programs and changes over time.

We have collected and reported to Congress the data that are available at this time. The NOMs are also available on the SAMHSA Web site, *www.samhsa.gov*. Each outcome measure is detailed in a table, and State profiles are available as well. The consensus that was needed to develop and implement the NOMs now needs to become widespread and used to guide the daily operations of provider organizations and individual providers to continue to improve service delivery systems.

CONCLUSION

As the Administrator of SAMHSA, I am steadfast in my commitment to lead SAMHSA and the people we serve toward achieving the best outcomes possible. Each of us lives and works in a time when behavioral health's impact on everyday life and overall health can no longer be set aside with a clear conscience.

SAMHSA's National Survey on Drug Use and Health indicates that nearly 21 million Americans who needed treatment for an illicit drug or alcohol use problem did not receive treatment. In addition, there were over 11 million adults who reported an unmet need for treatment or counseling for mental health problems in the past year, including 5.7 million adults who did not receive any mental health treatment at all. Helping more Americans achieve a healthy and rewarding life in the community in "the land of promise" is not a vague or lofty goal. It is an achievable milestone in our Nation's story which is already underway through advancements in science and research, the introduction of promising and effective treatments, systems transformation, public outreach and education, and strong national leadership and commitment.

Thank you for the opportunity to appear today. I will be pleased to answer any questions you may have.

Senator REED. Thank you very much, Dr. Cline.

We'll take 5-minute rounds and, let me begin.

One of the issues that is highlighted both by your testimony and Congressman Kennedy's testimony was the interaction between mental health and physical health. And the reports recently—and we've cited them, about shortened lifespan of people with mental health problems, should give us pause. It raises many, many questions, but among those—what is your sense of the ability of primary care providers to recognize and effectively treat mental health issues? And, on the other side of the equation, the ability of mental health workers to recognize physical issues, and get that patient into some type of health screening?

Mr. CLINE. I believe that we have been sorely inadequate on both fronts. I think that there is a great deal of potential that is just now being recognized. Again, this public health approach really emphasizes the need to address the comprehensive needs of individuals. We have many qualified experts who have been doing an in-

credible job of providing the services they provide, but those services have been so narrowly focused, that we have missed that broader picture of individuals.

I heard a very compelling story of someone who had struggled with their recovery, with mental illness. On the path to recovery, doing very well, only to die of a heart attack in their early fifties. So, I think there is, there's increased recognition across the States and communities about the need to integrate and address these needs, wherever possible.

Senator REED. I presume, also, that raises the stakes for the training programs that will allow both medical professionals and mental health professionals to recognize different disorders and at least recommend treatment, is that correct?

Mr. CLINE. I think that's absolutely true. And again, that's the opportunity—if you're working with an individual, and you have that person, and you have a relationship, and you're providing some aspect of their care, what a great opportunity, then, to broaden that to address these other areas, or make sure that, at least, that's coordinated with other aspects of care.

Senator REED. One of the areas that we're all concerned about, I know you are, Doctor, is measuring outcomes, which is a very difficult proposition in any endeavor, public or private.

Recently, there's been a transition from a performance partnership grant initiative that was directed by Congress during the last reauthorization, to the new national outcomes measures system. Why don't you give us an idea of the rationale behind the change, what you hope to accomplish, and why is this a better approach?

Mr. CLINE. The approach we have now is focused on recovery—recovery for individuals. What makes a difference in an individual's life, and for that person's family? And, that has changed in emphasis from kind of a quantitative, counting numbers of services, to a more qualitative aspect, and how is that making a difference?

These are the types of things that we know are important to help an individual obtain and then sustain their recovery, things like having a job, things like connecting with their family, decreased contact with the criminal justice system. Those types of issues which are meaningful in a person's life and are very, very relevant to their recovery.

So, it's a change from a focus on, specifically on treatment, and measuring that treatment, to a focus on recovering, and measuring recovery.

Senator REED. Now, do you think you have the information systems and the metrics to make this system work?

Mr. CLINE. These outcome measures have been in development for several years, again, this is a partnership that I referenced, with the States. The majority of States have been voluntarily submitting that data already to SAMHSA. There are 10 domains for getting all of those demands. For some States, that has been quite a struggle, in terms of developing that infrastructure. They have not had that capacity. So, SAMHSA is providing technical assistance, trying to work with those States so they will have that capacity to provide those data to SAMHSA. We're not there yet, but we're well on our way.

Senator REED. And, in that regard, in terms of outcomes, the Access to Recovery Program has been on the books and in the field for a few years now. Have you looked at outcome measures in that program relative to other programs? Have you drawn any preliminary conclusions?

Mr. CLINE. The preliminary outcomes are looking very good for the Access to Recovery Program. When the Program—and it's still in its relative infancy—so we'll track that data over time, as well. But, the initial data shows approximately a 70-percent abstinence rate for individuals who are discharged from the Access to Recovery program, a significant increase of about 20 percent for individuals, in achieving housing—independent housing—and over 25 percent increase in employment for those individuals. So, the preliminary data are looking very encouraging.

Senator REED. And, you're drilling down to the different treatment modes that they're using, and making connections in terms of what treatments they're getting and leading to success or failure?

Mr. CLINE. What we know so far is that we have broadened the number of providers who have been involved in that. We believe that that is significant. We don't have a large enough pool of that data yet to draw conclusions from that.

Senator REED. Thank you, Doctor, very much.

Senator Enzi.

Senator ENZI. Thank you for your testimony, and also the excellent answers to those questions.

I want to delve a little bit more into the recently released principles that included using the public health approach to deliver services, which eliminates funding silos, among other things. I want to know how you plan on carrying that out, but mostly what tools you need to carry out those objectives. What do we need to ensure that these funding silos can result in a better approach to delivering services? The coordination that was talked about?

Mr. CLINE. Thank you for that question.

I have more detail on this issue than I might have otherwise. Oklahoma was one of the States, one of the initial seven States that had received a transformation grant through SAMHSA several years ago. As part of that process, that allowed us to develop a plan, by State, individually to address the needs, recognizing that the structure in Oklahoma may be very different than the structure in Wyoming, or Arkansas, or Massachusetts, and so we don't have a one-size-fits-all. What that allows us to do is to identify the needs within those particular States, that allows us to then develop a comprehensive plan which looks—not only of the needs within the behavioral health system—but looks at the needs across the entire community, and the State.

As you know, there are many other entities that are involved in providing behavioral health care. So, that transformation is much broader, and that's where we get into the public health model, in terms of involving schools, and in terms of involving employers, and practitioners in hospitals, and other people in the community. So, some of the tools that are needed are that technical assistance to the States, to help them develop their own resources, to help

them explore their own needs and develop that plan, and then to implement that plan.

There also has been a great deal of sharing of that information from those seven States—now nine States, two other States were added—for that initial transformation effort, and we are spreading that even beyond that pool of nine States, and showing that. We recently had a conference where individuals from the States that have been actively engaged in this, were sharing this with other States. So, they can learn from the lessons that have been learned the hard way in some of those other States.

But, it's a very exciting transformation, there is a recognition across the board that we have not made the gains, even though people have been working incredibly hard and putting resources to meet those needs, we have not been as effective as we might be, if we had that more comprehensive public health approach.

Senator ENZI. I think this is related, and we talked about national outcomes just a moment ago, too, so this is a little bit of a follow up to that question, as well. For individuals with co-occurring conditions, is SAMHSA working with the States to develop the NOMS management system that will reduce the duplication of records? Such as duplication of information in paperwork?

Mr. CLINE. Well, there are two pieces, I think, that address that. There's the 10 domains that basically apply, although there are a couple with variations, applied to both the substance abuse and the mental health populations. So, that provides some equitable data, and that's why this was such a remarkable feat, to have consensus from both fields, across the country on these 10 domains for the National Outcome Measures.

We also are exploring, and helping States explore, the possibility of electronic medical records, which is a serious issue in terms of looking at some of that interoperability between those records. As you know, there are some confidentiality restrictions, in terms of 42 CFR for substance abuse services, and other things that present some challenges that may be unique to this field. But, I believe that, the people engaged in that process—and we're seeing great progress with that.

Senator ENZI. Yes, we're working on the Health IT, we put out a bill last year, and we're working from that basis and moving forward, trying to get some of the tools that are needed there, plus provide the confidentiality.

So, I'll yield the balance of my time.

Senator REED. Thank you, Senator.

Senator Murray.

Senator MURRAY. Thank you very much, Mr. Chairman, and I would like to submit my opening statement for the record.

Senator REED. Without objection.

[The prepared statement of Senator Murray follows:]

PREPARED STATEMENT OF SENATOR MURRAY

Mr. Chairman and Senator Enzi, thank you for holding this hearing as we begin updating our Nation's policies on substance abuse and mental health.

Unfortunately today, most of the agency's authorities have expired, and that lapse is occurring at a critical time. We have vet-

erans coming home from combat who need help with PTSD and other mental health challenges. They face the same stigma that many others face when they seek mental health care.

And we've all been horrified by what occurred at Virginia Tech. We have to make sure that people at risk of violence get the attention and treatment they need, and that those affected by the tragedy in Blacksburg get counseling and support.

I've been pleased to work on past SAMHSA reauthorizations. In 2000, we improved our focus on the needs of young people and created a grant program to address methamphetamine abuse. Since then, we've targeted underage drinking and preventing youth suicide.

MY THREE PRIORITIES

As we begin to update the act this year, I'm focused on several points.

First, we've got to make help *more accessible*. That means keeping up with the demand for services and making it easier for everyone to get those services—whether they have insurance or not. It means making sure that grant programs have sufficient funding to meet the needs of our communities.

Second, it's all connected. Individuals are not just individuals; they're part of a broader community. Mental health is connected to substance abuse to housing to employment and more. As I look at SAMHSA's programs, I see that it's all connected, and that's why our approach has to be *comprehensive and coordinated*.

One example of that is mental health parity. We know mental health is connected to physical health, and it should be treated that way by insurers. The inability to treat mental illness the way we treat physical illness has resulted in a fragmented treatment structure. It has also created a shortfall in the availability of services.

I'm pleased that our committee has passed mental health parity, and I'm eager to move that bill forward so that our entire country can begin to see the benefits of it. And I want to thank Chairman Kennedy and Senator Enzi for their work on mental health parity.

Third, when it comes to substance abuse and mental health, *early intervention* makes a difference. I'm especially interested in the support we can provide to young people. The truth is we can pay now—or we can pay later. Let's be proactive and help individuals and communities address these challenges early while there's still time to help them lead longer, healthier, and more productive lives.

I really want to thank our witnesses for testifying today and sharing their insights. In the fields of mental health and substance abuse, I've met so many people who are quietly working to help individuals change their lives and reclaim their futures. They do difficult work, and they don't often get the public credit they deserve. And I just hope that as we update the policies, we never lose sight of the people they serve, and how their work—and ours—can make a difference.

Senator MURRAY. Dr. Cline, my home State of Washington is facing a meth epidemic, no matter who I talk to—whether it's law enforcement, or drug counselors, or social workers, or community

leaders, they bring this up to me as the No. 1 issue that they are trying to deal with in their community, and I wanted to know if you could update me on what work your agency is doing to address the meth epidemic, and more specifically, do you think we need to provide more funding or more authority from Congress to deal with that issue?

Mr. CLINE. My belief is that the authority exists. We've been providing a great deal of technical assistance, as well as some grants, and Washington State, in particular, the Access to Recovery Program that we talked about earlier, is thriving and serving many individuals who are struggling with methamphetamine, specifically, in that State.

Again, we've provided that technical assistance, we've had grants to make certain that States were able to implement evidence-based practices. At one time, there was a misunderstanding or a myth in the field that people who were struggling with methamphetamine could not be treated, the treatments were not effective. It simply was not true, there are effective treatments for methamphetamine addiction. So, it's important to get that message out there, as well.

When we look at the national data, what we see is that the initiation, those people who are using methamphetamine for the first time, is actually on the decline. But, at the same time, we're seeing a significant increase in the number of people who are being admitted for methamphetamine treatment. So I know that many States are struggling to respond to meet that need, which is great.

Senator MURRAY. Do we have enough resources? Do you think we need more resources for that?

Mr. CLINE. There is great variability by States on that, so I wouldn't feel comfortable generalizing for the whole country. I know in some areas of the country, the methamphetamine epidemic is absolutely devastating, and those States have reported ongoing struggles in terms of meeting that need, in terms of workforce to actually meet the need, and treatment facilities that are trained with the workforce to be able to use those evidence-based practices, and other States where that has been less of an issue.

Senator MURRAY. I'm also very concerned, and have been working for some time on the issue of our children getting access to treatment services for mental health and substance abuse, and I know that SAMHSA has started to shift some resources more toward children, but we still have a really long way to go.

In my State, one of the challenges we have is not enough service providers for children, so that's a real barrier. Can you talk to us a little bit about your efforts to improve service and treatment options for children?

Mr. CLINE. Sure, and thank you for that question.

As part of this public health model, one of the areas of focus for SAMHSA is really to intervene as early as possible in that cycle of addiction, or mental illness. We know that if we can reach people at the early stages of their illness, the prognosis is much better, and the negative impact on the individual and family is greatly decreased.

SAMHSA, I think most people are aware, has a strong track record in terms of the systems of care approach, which is an innovative program for children and their families to address the needs

of those children who are struggling with serious emotional disturbance, which is a program that is comprehensive in nature that emphasizes collaboration of multiple sectors.

Most often children who are struggling with either addiction or mental illness, are not engaged with only one provider—they have special ed services through the school, they may be involved in child welfare, they may be involved with the mental health system. So, there's an effort through that particular grant program to make certain that all of those individuals are coming together to create one team that's focused on the needs for that particular family, rather than working in the silos.

And also, in the area of addictions, a great deal of concern, now, about underage drinking. And we worked with the Surgeon General's Office to release his Call to Action, which is focusing on the reduction and elimination of underage drinking, which is a persistent problem in our culture today.

Senator MURRAY. OK, I appreciate that. And finally, let me just ask you about Veterans—we know there's a high number of men and women coming home with PTSD and other mental health issues, and we're hearing more and more reports that are very disturbing. I know that the VA focuses on that, but I wanted to find out from you what SAMHSA is doing, if anything, and if there's anything else we should be looking at, as we get this influx of soldiers home.

Mr. CLINE. Thank you, again, for that question. SAMHSA is very concerned about this issue. We sponsored a conference, just within the last year, that focused on returning vets, we pulled people together from all over the country, asked States to have representatives from their VA systems, and from their mental health systems so that they could work together in a focused way to address those needs back in their States, again recognizing that we wouldn't simply be saying what is best for that particular community—we are an ongoing collaboration with the Department of Defense as well as the VA and the National Guard, and are actively engaged in that process, in terms of formulating any kind of contribution that SAMHSA could make toward that response.

Senator MURRAY. One of the big issues is the stigma attached to it, particularly for, "tough Army guys." Is there anything we should be doing to help our community better understand that, so that people will get the help that they need?

Mr. CLINE. SAMHSA has been engaged in an anti-stigma campaign, and again, partnering with several communities across the country, trying to encourage individuals to ask for help when that help is needed. We've had ongoing collaboration with Ad Council, trying to do PSAs that get out there and reach everyone, not just Vets, but everyone in those communities, because that prejudice is, of course, deeply rooted in our culture.

Senator MURRAY. Can you share some of those PSAs with the committee, so that we can take a look at them?

Mr. CLINE. Absolutely.

Senator MURRAY. Great, okay. Thank you very much.

Mr. CLINE. Thank you.

Senator REED. Thank you very much, Senator Murray.

Senator Murkowski.

STATEMENT OF SENATOR MURKOWSKI

Senator MURKOWSKI. Thank you, Mr. Chairman.

Dr. Cline, I appreciate your testimony here this morning, and all that you do with SAMHSA.

You mentioned the suicide rate, and as you know, that is something that we, in the State of Alaska, continue to struggle with, particularly in our more remote communities, and our villages, and particularly with our young Alaska Native men. Our statistics are, needless to say, very, very, very troubling.

And you mentioned coming from a small town in Oklahoma, and knowing the impact to a small community. When we have two young men or three young men take their lives over the course of a winter in a village where you only have a couple hundred people, it doesn't just bring down that family, it destroys that whole community.

I feel helpless as to what we can do in a State like Alaska where we are so remote, our villages are so small and our problems with substance abuse are literally killing our people and our communities.

I would like for you to comment on how, from a rural perspective, we can better work with SAMHSA on—particularly our suicide rate—to reduce that to the extent possible. We're utilizing some tele-medicine, tele-behavioral health technology, I think we're starting to make a difference, but it's difficult when we don't have the facilities.

We can have the programs, and—I'll ramble for just a moment, if I might—when you're talking about the national outcome systems, and the way that we address accountability, focus on a qualitative rather than quantitative approach. I appreciate that, but I get concerned that if we have to adhere to an accountability standard, we're going to lose our ability to really cater some programs that would work in a very different setting, like a remote Alaska Native village, than what we do here in Washington, DC.

Can you give me some level of assurance on that, that we will still have the ability for Manilic Health Corporation to have their treatment camp, utilizing cultural and their Native ways to provide for a level of treatment, that we're not going to be bumping up against a one-size-fits-all approach, because we have to be able to account for these moneys?

So, my question is two-fold—what can we do on the suicide front, and with this focus on a National Outcome System, will we still have the flexibility that we need in many rural parts of the country to provide for culturally sensitive programs?

Mr. CLINE. Thank you for the question.

I had a brief conversation with someone from Alaska earlier, before this meeting, who talked about the challenge of the nearest center being several hundred miles away for those individuals to access any type of care. So, and obviously in that situation it's difficult to engage the entire family, in any kind of family-oriented treatment, which we know has often been most effective, in many situations.

The outcomes that you talk about, I believe are helpful tools, if you're managing a State system, or whether you're managing an

individual program, so that you have an idea of the effectiveness of your programs, and you use that, then, as a management tool for yourself. And I've managed both those programs, and at the State level, and that information is very helpful.

There has been a great deal of concern about the disparities that you're mentioning, SAMHSA has specifically six suicide grants that are targeted for tribes and Alaska Natives, so we're working hard to make sure that those grants are as available as possible. And again, in ensuring that the tribes are using those dollars and those grants to provide culturally competent services within their community, it's not a cookie-cutter approach in doing that.

SAMHSA has also has been engaged in developing and updating a National Registry of evidence-based programs and practices, this is a larger registry that looks at evidence-based practices that actually encourage those communities and others to submit designs that they know have been successful, in their particular communities. So, an individual community could go to this registry, look at this registry, and say, "Here are some similar characteristics that we share from our community with this particular community, and it worked there, so we may try that."

The threshold is a little bit different, you're not looking at, necessarily, randomized controlled studies, or a threshold that is so incredibly high that it doesn't address the cultural competency issues of other programs or communities, so we're very hopeful about that being a useful tool for communities, as well.

Senator MURKOWSKI. I can't pass up the opportunity to make sure that you're invited to come up to the State and visit some of our communities, so that you can appreciate some of the challenges that we face. We look forward to it.

Mr. CLINE. Thank you very much, I appreciate that invitation.

Senator MURKOWSKI. Thank you, Mr. Chairman.

Senator REED. Thank you, Senator.

Senator Burr.

Senator BURR. Thank you, Mr. Chairman.

She usually invites you in the dead of winter, I'll just warn you.

[Laughter.]

Mr. CLINE. The travel rates will be cheaper, that will be good.

STATEMENT OF SENATOR BURR

Senator BURR. Dr. Cline, welcome. We're delighted to have you at SAMHSA. I think it's apparent, sitting here and listening to all of the members field questions to you, that everybody's problem is a little bit unique, it changes a little bit State to State, region to region. It probably highlights why your job is vitally important, and why in the functions of SAMHSA we should, very much be focused on outcomes, and less on process, because the objective here is, how do we help as many people as possible, and how do we keep them part of their communities, and more importantly, productive parts of their communities? But, we do that with the real understanding that we've got challenges.

I want to go into two areas, the first one, homelessness, chronic homelessness, specifically. Because we know SAMHSA partners with the Department of Education under the Safe Schools, Healthy Students initiative. I think it's safe to say Senator Reed and I, and

I'm sure others, think that SAMHSA should also partner with the Department of Housing and Urban Development to provide targeted funding for mental health and substance abuse services at permanent supportive housing facilities, to help end this cycle of chronic homelessness that exists.

The city of Portland recently reduced the number of chronically homeless by 70 percent, when the city, the county, the Housing Authority partnered to provide resources so agencies could open 480 new units of permanent, supportive housing. And I know SAMHSA has the authority to provide some funding to organizations providing services to homeless individuals, but how much of that currently supports this highly cost-effective model, like Portland?

Mr. CLINE. I don't have an exact figure for you, Senator, but what I can tell you, the key word that I have heard in your question was really around partnership, and the effectiveness of the program that you describe.

What we found is that when we provide that flexibility, especially in the area of homelessness, that is a community-based issue and challenge, that there are so many individual characteristics, by community, that we want to ensure that we are not locking in one particular remedy that we feel can address that issue. So, that flexibility, that partnership through multiple agencies, we feel, has been the most effective tool in addressing homelessness.

Senator BURR. Well, as you know, Washington has a long history of thinking that they know best. And, I think what you've heard up here, is that communities know best. And those partnerships, I believe, are absolutely valuable.

Area two—disaster response. It's my understanding, if correct, that SAMHSA is authorized to take up to 2½ percent of your overall budget, the discretionary budget, and to surge that to address mental health and substance abuse needs in response to an emergency. In addition, FEMA receives funding from the Federal Government for mental health and substance abuse, in the case of emergencies.

One, is my understanding correct, and can you share with us the process that both agencies go through, if they do at all, to coordinate the activities, and specifically, who calls the shots, when you've got two entities like that involved?

Mr. CLINE. Well, in answer to the question of who calls the shots, the majority of these disaster response dollars, when they go to the States are actually implemented, then, by the States. So, SAMHSA is not actually providing the services, although we have provided technical assistance, and we have also deployed staff. After the hurricane, I believe we had about 250 of the 500 staff at SAMHSA who were actually deployed to help provide, you know, in that particular crisis.

The FEMA dollars that come, of course, from FEMA, travel through SAMHSA and are provided for crisis counseling response in an emergency situation.

We also have other dollars through the surge grant, which is available, but is not administered through FEMA.

Does that help with that?

Senator BURR. Sure.

Let me ask, SAMHSA-specific, what kind of pre-event research, planning, training goes on to prepare for and respond to the mental health needs of a disaster?

Mr. CLINE. There's a great deal that goes on, and SAMHSA has actively partnered, again, with the States to ensure that they have plans in place that they are ready to implement. There have been several national conferences, and using the same model that I described earlier around the returning Vets, where States have been encouraged to bring teams of individuals, those very same teams that would be utilized in an emergency, not just the behavioral health individuals, but other individuals that would be involved from FEMA and other emergency preparedness response organizations within their State, could be members of Red Cross and others, to make sure that they have that plan in place and ready to go.

So, we've encouraged that, we've provided, again, resources and technical assistance to make sure that the States are prepared.

Senator BURR. Last thing, as it relates specifically to SAMHSA's experiences in Katrina and Rita—what three things would you say that SAMHSA learned to improve the provisions of mental health and substance abuse services, post those disasters?

Mr. CLINE. I think one of the, and this is really from my own perspective, and not necessarily from SAMHSA's, but I think that one of the lessons learned has been the regional impact of disasters, and the importance to make sure that there is coordination and communication across States and across jurisdictions. I think that was less clear than before, when specific disasters were much more focal in their nature, and so the response was much more focal.

What we saw from the hurricanes was that incredible ripple effect, that went across multiple States, States that were directly impacted by the hurricanes, and also the States that were impacted by the exodus of individuals leaving, so I would say that was the biggest lesson learned.

I think another lesson learned was the importance of having a flexible workforce who can be deployed to meet that need in time of crisis. What we saw with this hurricane response was that many of the professionals left, and didn't return to their communities, which left an incredibly fragile system without an adequate workforce to address that need. And that had not been anticipated.

Senator BURR. Thank you, Dr. Cline.

Mr. CLINE. Thank you, sir.

Senator BURR. Thank you, Mr. Chairman.

Senator REED. Thank you very much, Senator Burr.

Dr. Cline, thank you for your testimony, I know we all look forward to working with you through this reauthorization, and all of your endeavors. Thank you.

Mr. CLINE. Thank you, Mr. Chairman.

Senator REED. Let me now ask the third panel to come to the witness table, please.

I would like to first introduce Ms. Lisa Halpern, and welcome you, Lisa, here today.

Lisa is currently the Program Director of the Dorchester Bay Recovery Center in Dorchester, Massachusetts, and she works very

closely with the National Alliance for the Mentally Ill, and she is a representative of NAMI today.

She has a very distinguished academic and professional biography. But, while she was a student of the Kennedy School in 1999, Lisa was diagnosed with schizophrenia. After a year's leave, Lisa was able to return to Harvard, and with the support of school administrators and faculty, completed her studies at the Kennedy School of Government in 2001. So, as a fellow alumni of the Kennedy School, I'd like to welcome you here today. Thanks.

Lisa has worked at the Office of the Commissioner of Mental Health in the Commonwealth of Massachusetts. She is an active volunteer in NAMI's Massachusetts affiliate, volunteering as a Peer Mentor Program Coordinator/Trainer, and doing much to help so many people, we thank you for that.

Lisa is a 1995 summa cum laude graduate of Duke University with a double major in economics and public policy, and she's the recipient of numerous awards including the 2006 Massachusetts Behavioral Help Partnership Recovery Award. We thank you for being here today.

I would now like to also recognize and introduce Roger McDaniel.

Roger, Senator Enzi had to leave for the floor, he's managing the FDA bill, he so much wanted to introduce you personally, I know you're old friends from Wyoming.

Roger has a remarkable background, also, he's the Deputy Director of the Wyoming Department of Health, he's responsible for mental health and substance abuse services. He began his public life at the age of 22 in the Wyoming Assembly, where he served for 10 years. In 1980, he received his law degree from the University of Wyoming. Together with his wife, Patricia, they have been very active in numerous philanthropic endeavors, including Habitat for Humanity, and then in 1996, Roger enrolled in a Master's of Divinity Program at Iliff School of Theology in Denver, where he was ordained as a Minister in 1999.

Welcome, Reverend.

And, he was a fellow at the Cathedral College at National Cathedral in Washington, DC. We look forward to your testimony.

And now, I'd like to defer to Senator Burr to introduce Mr. Allebaugh.

Senator BURR. Thank you, Mr. Chairman, let me at this time welcome all of our witnesses, and we're particularly pleased to have a Duke graduate. If you can't live in North Carolina, at least we like to educate you there.

[Laughter.]

Terry Allebaugh is a founder and Executive Director of Housing for New Hope, located in Durham, North Carolina, as well. Terry founded Housing for New Hope in 1992, after several years of leading a community shelter. I had the privilege to visit his organization, whose mission is to encourage and assist homeless people, and other persons in crisis, to move toward stable, hopeful and independent lives.

Under Terry's leadership, Housing for New Hope established transitional housing programs, The Phoenix House, and the Dove House, as well as permanent supportive housing facilities for folks with disabling conditions, such as mental illness.

They also provide crisis assistance for families with children, and disabled adults who are at risk of becoming homeless.

Terry operates a substantial Project for Assistance and Transition for Homelessness, the P.A.T.H. Program for outreach to the chronically homeless who are mentally ill. Terry is a Board Member of the North Carolina Council to End Homelessness, and is Chair of the Council to End Homelessness in Durham, North Carolina.

He earned his Bachelor Degree at Buria College, and has completed 2 years of education at Duke University Divinity School.

Terry, it is a delight to have you here to testify, as it is for all of our witnesses.

Thank you, Mr. Chairman.

Senator REED. Thank you, Senator Burr.

Ms. Halpern, why don't you begin, and then we'll go to Mr. McDaniel, and then Mr. Allebaugh.

STATEMENT OF LISA HALPERN, CONSUMER, MEMBER OF THE NATIONAL ALLIANCE ON MENTAL ILLNESS (NAMI), DORCHESTER, MASSACHUSETTS

Ms. HALPERN. Thank you all. Senator Reed, and members of the committee, I am Lisa Halpern. I currently work as Program Director of the Dorchester Bay Recovery Center run by the VinFen Corporation in Dorchester, Massachusetts. At the Center, I coordinate and provide peer-directed services, support, and education to promote recovery for consumers living with mental illness and substance abuse. I also work at NAMI's Massachusetts affiliate as manager of In Our Own Voice, an outreach and support program in which consumers help educate the public about mental illness.

My story, like each of the millions of Americans living with serious mental illness, is unique, but what it demonstrates, as do so many others, is that recovery is an achievable goal if you are able to access the necessary treatment and support services.

The overt onset of my schizophrenia occurred when I was in my mid-twenties and had completed undergraduate studies at Duke University, graduating summa cum laude with double majors. I then received two prestigious merit-based fellowships to study at Harvard.

However, when I began studies at the Kennedy School in 1998, I started getting lost on a three-block walk to school. I then realized I was unable to count simple change, all the coins look identical to me. So, I began to pay for everything with $20 bills. It was clear that I would need a break from graduate school and I took a 1-year medical leave, as by that time, I had lost the ability to read, to write, and my I.Q. was measured at 70, borderline mental retardation.

During this time in June, 1999, I was first diagnosed with schizophrenia. When I returned to Harvard that fall, I was fortunate to receive extraordinary support from school administrators and faculty. So, I was able to complete my graduate studies in 2001, and then I worked for 2 years at the Office of the Commissioner of Mental Health in Massachusetts.

In 2003, I became the first peer counselor for an innovative, newly created, assertive community treatment program run by

Westridge Community Services, that targets individuals with co-occurring mental illness and substance abuse. While working at Westridge, I also became active in NAMI's Massachusetts affiliate as a speaker, manager, and trainer for the In Our Own Voice Program, a recovery-based consumer speaking program.

Senators, what has really made the difference in my path toward recovery is not just being able to access medication to manage the symptoms of my illness, but also being able to engage in self-directed care and having peer support. This is central to what proven evidence-based models, such as Assertive Community Treatment—often called ACT—are all about.

In examining the current State of publicly funded mental health services across the Nation, NAMI has found that there is an almost total absence of uniform gather-reporting systems, designed to measure whether or not States are investing in effective models, such as ACT, and whether or not there's fidelity to evidence-based programs.

NAMI urges the committee to include in SAMHSA reauthorization legislation an initiative to establish, in consultation with all stakeholders, especially consumers and families, outcome measures for States that will provide consistent, reliable information on State systems and services.

Having worked as a peer support specialist for a number of years and having benefited personally from peer-led support groups and human services training, I can tell you that ACT works. Unfortunately, only a small percentage of people living with schizophrenia and bipolar disorder are accessing evidence-based, recovery-oriented services, such as ACT.

NAMI's Grading the States Report, published last year, found that less than 10 percent of people with serious mental illness lived in communities that had ACT programs available.

Mr. Chairman, in my full written statement there are a number of suggestions from NAMI for SAMHSA reauthorization. For the time being, I will stop. Thank you for the opportunity to share my story with the committee.

[The prepared statement of Ms. Halpern follows:]

PREPARED STATEMENT OF LISA HALPERN

Chairman Kennedy, Senator Enzi and members of the committee, I am Lisa Halpern. I currently work as Program Director of the Dorchester Bay Recovery Center, run by the Vinfen Corporation in Dorchester, Massachusetts to provide peer-directed and operated services, support and education to promote recovery. I also work at NAMI's Massachusetts affiliate as Manager of In *Our Own Voice*, an outreach and support program in which consumers help educate the public on mental illness.

Mr. Chairman, my story—just like that of millions of Americans living with serious mental illness—is unique to me. But what it does share in common is an overriding theme that recovery is possible, if the right systems and supports are in place. First, a little background on my personal story:

Unlike many people living with schizophrenia, the overt onset of the disorder occurred for me when I was already in my twenties and had already completed undergraduate studies at Duke University, having graduated summa cum laude and Phi Beta Kappa, with double majors. I then received two merit-based fellowships to study at Harvard. It was there, in June 1999, that I was first diagnosed with schizophrenia and had two stays at McLean Hospital that year. This devastating thought disorder had a profound impact on my functioning and resulted in memory loss and the inability to manage even the most basic tasks such as counting change, reading and other activities of daily living.

After 1 year of medical leave, I was able to return to the Kennedy School of Government at Harvard. I was fortunate to receive extraordinary support from school administrators and faculty (for example, more time for examinations and class credits for summer research). With continuing support through a Kennedy Fellowship and the Paul and Daisy Soros Fellowship for New Americans, I was able to complete my graduate studies in 2001. After completing my graduate studies, I spent 2 years at the Office of the Commissioner of Mental Health in Massachusetts.

In 2003, I joined a newly created assertive community treatment program in Cambridge run by Westbridge Community Services and worked as the program's first peer counselor. At Westbridge, I got my first experience supervising and working with other peer specialists, participating in a Wellness Recovery Action Plan (WRAP), offering staff training on mental illness, and providing family and participant outreach, education and therapy for people with severe and persistent mental illness and substance abuse disorders. In 2003, I also became active in NAMI's Massachusetts affiliate as a speaker, coordinator and trainer for NAMI's *In Our Own Voice*, a recovery-based consumer speaking program.

Mr. Chairman, at the outset I would like to express NAMI's strong support for S. 558, the mental illness insurance parity legislation reported by the committee back in February. NAMI strongly supports this important measure to require employers and health plans to cover treatment for mental illness on the same terms and conditions as all other health conditions. This legislation has been stalled in the Congress for too many years. NAMI applauds your efforts to move this bill forward early in the 110th Congress. We look forward to working with you to move it to the full Senate as soon as possible.

REAUTHORIZATION OF SAMHSA

Before sharing with the committee NAMI's recommendations on legislation reauthorizing SAMHSA, I would like to echo the sentiments of the President's New Freedom Initiative Mental Health Commission report in noting that our Nation's public mental health system remains a "system in shambles."

In March 2006, NAMI released a comprehensive report on the performance of States in meeting the needs of adults with serious mental illness. Our report "Grading the States" is the first comprehensive survey and grading of State adult-public mental healthcare systems conducted in more than 15 years. Public systems serve people with serious mental illnesses who have the lowest incomes.

NAMI's report makes clear that nationally, the system is in trouble: the report gives the Nation a grade of D for its system of care for people with serious mental illness. The report also documents that too many State systems are failing—only 5 States received a B (Connecticut, Maine, Ohio, South Carolina, and Wisconsin), 17 States received Cs, 19 States got Ds, and 8 got Fs (Iowa, Idaho, Illinois, Kansas, Kentucky, Montana, North Dakota, and South Dakota).

Each State grade is based in part on a "take-home test," in which survey questions were submitted to State-mental health agencies. All but two States responded. Colorado and New York declined. They have been graded "U" for "Unresponsive." Based on the surveys and publicly available information, States were scored on 39 criteria. Consumer and family advocates also provided information through interviews that contributed to State narratives.

The report also included a "Consumer and Family Test Drive," a unique, innovative measurement. NAMI had consumers and family members navigate the Web sites and telephone systems of the State-mental health agency in each State and rate their accessibility according to how easily one could obtain basic information. The report contains a narrative for each State that also includes a list of specific "Innovations" and "Urgent Needs" to help advocates and policymakers further define agendas for action. An overall list of innovations provides an opportunity for States to learn from one another. As the grade distribution in the report demonstrates, our Nation still has a long way to go to achieve a "New Freedom" for people living with serious mental illness—a freedom based on recovery and dignity. NAMI is planning a follow up report in 2008 and we hope to see long overdue improvements in the results.

As this committee moves forward on SAMHSA reauthorization legislation, NAMI would urge you and your colleagues to keep these goals of recovery and independence foremost in mind. Along those lines, NAMI would make the following recommendations.

Establishment of State Outcome Measures and Accountability

SAMHSA should be required to establish outcome measures for States, building on previous initiatives such as the National Outcomes Measures initiative (NOMS), the State Pilot indicator Grant Project, and other related initiatives. In consultation

with providers, consumer and family organizations, and State-mental health agencies, SAMHSA should be directed to develop measures that will provide consistent reliable information on State systems and services.

Obviously, State and local public mental health systems will need some time to adopt and implement such measures. However, as a nation we need to set ourselves toward reaching a goal for meaningful outcome measures that allow us to assess the performance of State-mental health agencies and local public sector programs. In NAMI's view, the most effective means of achieving this is to have SAMHSA require every State, as a condition of receipt of funding for services and supports from the mental health block grant, Transformation State Incentive grants, and child mental health systems of care grants, to report on all outcome measures developed by SAMHSA.

It is also worth noting that while some reporting on the types of services provided is required under current law, these reporting requirements are not generally linked in any way to evidence-based practices that are designed to deliver measurable outcomes in terms of recovery such as integrated treatment for individuals with co-occurring mental illness and substance abuse, assertive community treatment (ACT), peer counseling and supports, multi-systemic therapy for children and adolescents, and family psychoeducation, to name just a few.

Despite years of discussion in the mental health field about evidence-based practice, we are still falling short on uniform data on the availability of these services across States or regions or the degree to which programs that provide these services achieve fidelity to standards developed by SAMHSA itself. SAMHSA authorization provides us with an important opportunity to make progress toward this objective.

Establishment of Federal Interdepartmental Task Force on Mental Health

NAMI supports the creation of a Federal Interdepartmental Task Force on Mental Health that should include involvement from the vast array of Federal agencies that administer programs that touch the lives of children and adults living with mental illness and substance abuse disorders. This should include the Secretaries of Housing and Urban Development, Labor, Education, Veterans Affairs, Health and Human Services (including CMS, SAMHSA, CDC, NIH and HRSA), the Social Security Administration, and the Attorney General. The goals of this Task Force should include:

1. improved coordination of mental health policy in the operation of pertinent Federal programs;
2. identification of policies and practices that contribute to fragmentation in care-delivery and barriers to care-integration;
3. development and implementation of interagency demonstration programs to foster mental health promotion, early intervention, and recovery-focused services; and
4. an annual report to Congress from the respective Secretaries which shall include recommendations for fostering improved collaboration and coordination of mental health policy, financing and management of recovery-focused service-delivery.

Program Sustainability Through Consumer and Family Engagement

SAMHSA has made enormous progress in recent years integrating the views of consumers and families into every major activity at the agency. This is a tremendous step forward. Unfortunately, this progress is not always mirrored at the State and local level. In order to jump start this process at the State and local level, SAMHSA and CMHS should be granted the authority to require State and local government recipients of SAMHSA funding above a specific threshold to allocate at least 5 percent of such funds to one or more not-for-profit organizations that represent consumers and families, to ensure that such organizations are able to participate in all aspects of planning and implementation of the SAMHSA grant or program.

Reducing the Use of Seclusion and Restraint

When SAMHSA was last reauthorized by Congress in 2000, this committee included a new Part H that contained requirements pertaining to the rights of residents of hospitals (private and public), nursing facilities, intermediate care facilities, or other health care facilities that receive Federal funds, including restrictions on the use of restraints and seclusion. NAMI supports expansion of these requirements through establishment of a new training and technical assistance center to focus on the prevention of seclusion and restraint in public and private facilities that provide mental health services to adults and children. Such training and technical assistance should include assisting States in facilitating the use of psychiatric advance

directives for consumers in the community and the implementation of PADs by facilities.

It must also be pointed out that although the Children's Health Act of 2000 required that regulations be promulgated to give effect to Part H within 1 year of enactment, these regulations have never been issued by SAMHSA. Although some progress has been made in reducing the inappropriate use of restraints and seclusion, far too many children and adolescents continue to die or suffer serious injuries resulting from the inappropriate use of these aversive measures. Thus, we urge the committee to include in statute specific standards pertaining to restraints and seclusion in facilities and programs covered under Part H. At a minimum, these should include:

• Requiring that thorough and comprehensive face to face evaluations of all individuals placed in restraints or seclusion be conducted by a physician or licensed independent practitioner within 1 hour of the time that these measures are instituted.

• Continuous monitoring of individuals in restraints or seclusion, either face to face, or using video and audio equipment.

• Debriefing of staff involved in the use of restraints or seclusion after each incident, preferably involving the individual subjected to these measures as part of the debriefing process. Debriefing has been shown to be very effective in sensitizing staff to alternative, less draconian measures for de-escalating crises.

• Limits on the length of orders authorizing the use of restraints and seclusion to 1 hour for individuals under 18 and 2 hours for adults.

• Requirements that all deaths and serious injuries that occur within 1 week of the time restraints or seclusion are used must be reported by the facility in which these measures were instituted to the designated Protection and Advocacy agency located in the State in which these deaths or serious injuries occur. Additionally, all deaths and serious injuries that occur beyond 1 week of the time restraints or seclusion that can reasonably be assumed to be related to the use of these measures should be reported as well.

Separate Legislative Proposals for SAMHSA Reauthorization

NAMI recommends that this committee consider amending any SAMHSA reauthorization bill to add separate legislation that would improve the performance of our Nation's mental health system and benefit the most vulnerable children and adults living with mental illness.

Reauthorization of the Garrett Lee Smith Memorial Act.—Suicide remains the third leading cause of death for those between the ages of 10 and 24 and the second leading cause of death for American college students. Programs under the Garrett Lee Smith Act (first authorized by Congress in 2004) have been highly successful helping States and localities, as well as colleges and universities address this epidemic. This committee should reauthorize and expand this highly successful program.

Keeping Families Together Act (S. 382).—Every year, thousands of families across the country are forced to give up custody of their children to the child welfare and juvenile justice systems to secure mental health services. The Keeping Families Together Act—introduced by your colleague Senator Susan Collins—is an important effort to keep children with mental illnesses who are in need of services at home and in their communities and most importantly, with their families. It encourages States to build effective systems of care for children with mental illnesses and their families and move away from costly residential and institutional services that too often require families to transfer custody of their children to the State to access these costly services.

Services for Ending Long-Term Homelessness Act (S. 593).—In order to make continued progress toward the national goal of ending chronic homelessness by 2012, it is critical for HHS and SAMHSA to step up and increase investment in services in permanent supportive housing that are needed to help people with mental illness and co-occurring substance abuse disorders from falling back into chronic homelessness. SELHA—introduced by Senators Richard Burr and Jack Reed—achieves this critical goal and should be a part of SAMHSA reauthorization legislation.

Thank you for giving me this opportunity to provide input to the committee.

Senator REED. Thank you very much, Lisa, not only for your story, but your courageous example. Thank you so much.

Mr. McDaniel.

STATEMENT OF RODGER McDANIEL, DEPUTY DIRECTOR, WYOMING MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES DIVISION, CHEYENNE, WYOMING

Mr. DANIEL. Mr. Chairman, Senator Burr, thank you for the opportunity to speak with the committee as you consider the reauthorization of SAMHSA.

I want to begin by acknowledging the excellent work that is being done by SAMHSA, NASADAD, NIDA, and others, to advance substance abuse practice and policy beyond the myths, using science to improve the outcomes.

Mr. Chairman, over the last 40 years, I have viewed the substance abuse system, in particular, from several perspectives—as a State lawmaker, as a lawyer, a jail chaplain, and working in child welfare. I have worked with addicted persons, and the programs that serve them.

However, it was not until I experienced these problems as a parent, that I began to really seek the answers to hard questions, such as—why do people use drugs when the consequences are so dire? With excellent treatment, our family member did well and has gone on to enjoy a good life, interrupted only briefly by substance abuse.

But while that was happening, I saw countless addicts in corrections and the child welfare system living out actively hopeless lives, getting either no treatment, or ineffective treatment. Myths such as, an addict really wants to have it before treatment will work, effectively substitute for the responsibility of the system to provide outcomes. Contrary to popular notions that addiction is the result of character defects or bad parenting, addiction is a chronic, relapsing brain disease characterized by compulsive drug seeking and use, despite harmful, even catastrophic consequences. While the initial decision to use drugs is a choice, there comes a time when continued abuse turns on the addiction switch in the brain. That time can vary, depending on factors ranging from genetics, to environment, to the type of drug, and frequency of use, but it is an actual rewiring of the brain chemistry that trips the switch. Choice is then replaced by a brain-driven compulsivity to use drugs.

An important goal of the current research is to understand, through the use of various scanning technologies, the changes in the brain that facilitate a transition from occasional, controlled drug use, to the loss of behavioral control over drug-seeking and drug-taking that defines chronic addiction.

I have provided for the committee a picture of some of the brain scans from a NIDA publication that dramatically depict the changes that physically occur in a brain as a person transcends from nonuse, to addiction, and then the regeneration of the brain out into abstinence following treatment.

The brain science should be the foundation of treatment, as well as public policy. The brain scans demonstrated, for example, why typical probation programs do not work as well as fully supervised drug courts and why the 15/22 rule of the Adoption and Safe Families Act can be a very effective tool in coercing addicted parents into treatment and recovery.

Mr. Chairman, Senator Burr, there's a really remarkable story in yesterday's Washington Post about the tragedy at Virginia Tech.

Headline, Cho Didn't Get Court-Ordered Treatment, which amply demonstrates some of what representative Kennedy and others have talked about, about the fragmented system. There's a quote in the story that talks about how Mr. Cho did not receive treatment, was court-ordered to receive treatment, and it says, quoting a counseling center official, "When a Court gives a mandatory order that someone get out-patient treatment, that order is to the individual, not the agency." And, then it concludes with this remarkable statement that demonstrates the problems in the system at the ground-level. "The one responsible for ensuring that the mentally ill person receives help in these sorts of cases," he said, "is the mentally ill person."

Mr. Chairman, that reality is also in substance abuse, as well. And, it demonstrates the significant fundamental gap between the science and the practice.

Mr. Chairman, I also want to say that Wyoming and the other States feel as strongly as any Member of Congress about accountability. The States working with SAMHSA and NASADAD have made excellent progress on the establishment of National Outcome Measures.

In Wyoming, the Governor and the legislature have enacted legislation, the legislature has enacted legislation at the Governor's recommendation, requiring the use of the National Outcome Measures, and requiring that we withhold funds from providers until we have agreements on measuring those outcomes.

Finally, I encourage the Congress to provide flexibility. As Senator Burr and others acknowledged, substance abuse is ultimately a local community experience. The problems of substance abuse are different, not only from State to State, but within States from community to community, and they will be solved more by local community leadership. Those who live in the neighborhoods affected have more at stake than do Government agencies.

My time has expired and, Mr. Chairman, I'll close by encouraging greater diffusion of the scientific knowledge of the nature of addiction, incentives for continued accountability, and a system flexible enough to encourage and empower local community-based leadership as partners with the Congress and the States to do this urgent work.

Thank you.

[The prepared statement of Mr. McDaniel follows:]

PREPARED STATEMENT OF RODGER MCDANIEL

Mr. Chairman, Ranking Member Enzi and members of the committee, I am Rodger McDaniel. I am the Deputy Director of the Wyoming Department of Health with responsibility for the Mental Health and Substance Abuse Services Division. I am also a member of the National Association of State Alcohol and Drug Abuse Directors (NASADAD). I am grateful for the opportunity to share my thoughts with you as you consider legislation reauthorizing the Substance Abuse and Mental Health Services Administration and am appreciative of the work of this committee and your colleagues in the Congress to help the States meet the growing challenges of substance abuse and addiction.

Some time ago I came across a May 9, 1897, issue of the Saratoga, Wyoming newspaper, The Saratoga Sun. A front page editorial read in part:

> "There is entirely too much drunkenness in this town for the comfort of peaceable and law abiding people. It is hardly possible for a lady to pass along the street without having drunken and profane language issuing from the saloons there. Drunk men and lewd women should be made to keep their places."

Of course, these problems were not new to the 19th century west. From ancient times, societies have grappled with the problems caused by the excessive use of mind altering substances. For the better part of all of those efforts over many centuries, there was little in the way of science to illuminate the path. In the last decade, that has changed primarily because of an explosion of good science to provide guidance. However, it remains the case that both policy and practice are based, more often than we would like, on myth than on science.

The preface to *Rethinking Substance Abuse: What the Science Shows and What We Should Do About It*, a 2006 book edited by doctors William R. Miller and Kathleen M. Carroll includes this "to the point" history of attempts to remedy substance abuse and addiction.

> "Historically, problem drinkers have been whipped, dunked, shocked, poisoned with potions, chained, dialyzed, terrorized, drugged with hallucinogens, Interferon, and all manner of psychiatric medications. More recently, the users of illicit drugs have been lectured to, fined, imprisoned, 'scared straight,' given 'attack therapy,' and sent to boot camps. * * * The bad news is that very little science has found its way into practice." [1]

The problems associated with substance abuse have cut a wide swath across our society limiting the potential of individuals and institutions. According to the National Conference of State Legislatures, drug abuse costs exceed $350 billion each year, accounting for more than 550,000 deaths.[2] The neglected and abused children of addicted parents overwhelm the foster care system. Spending increases in the corrections system and Medicaid are driven in large measure by drug abuse and addiction. Homelessness and addiction are interrelated as well. A May 2005 report on homelessness in Wyoming found substance abuse a major factor in 22 percent of the homeless population.[3] I have attached a copy of this report to my testimony for the committee record.

[Editor's Note: Due to the high cost of printing, previously published materials are not reprinted in the hearing record. The report "Homelessness in Wyoming may be found at http://uwyo.edu/wind/connect/newsletter/past.asp?issue=vol8iss1.inc#spotlight.]

The Wyoming Department of Health is currently completing a study of the mental health and substance abuse needs of veterans of the wars in Iraq and Afghanistan. Those wars aside, it is recognized that the rate of alcohol dependence is greater among the veteran population than among others. The New York Times reported in March of this year that alcohol, though "strictly prohibited by the American military in Iraq and Afghanistan, is involved in a growing number of crimes committed by troops deployed to those countries." [4] The well known linkage between post traumatic stress disorders and substance abuse and addiction is also a reliable predictor of the additional weight returning servicemen and women will put on already strained State substance abuse and mental health treatment services.

Despite the cause for concern, we are beginning to see signs of the success of the combined State, Federal and local community efforts. First time meth use among Wyoming high school students has declined. Given the uniquely addictive nature of this dangerous drug, this is a significant success of our joint prevention efforts. From 1999 through 2006, first time meth use among high school students in Wyoming declined by about one-third. Importantly, Wyoming has also seen effective law enforcement efforts reduce the numbers of clandestine lab operations by more than 80 percent since 2001. Certainly meth continues to enter the State from Mexico and other places but the decline in State located labs is a meaningful development given the health and environmental dangers posed by these labs.

Five years ago Wyoming had few meaningful standards for providers. Today we have research-based standards applicable to any provider receiving State funds or court referrals. Providers certified under those strong standards have increased by 63 percent in the last 5 years meaning there are more providers who are better qualified than ever before. During that time, Wyoming has gone from three struggling drug courts to having 25 successful drug courts across the State with documented outcomes saving tax dollars and holding addicted offenders accountable while encouraging them into recovery.

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[1] *Rethinking Substance Abuse: What the Science Shows and What We Should Do About It,* William R. Miller and Kathleen M. Carroll editors, Guilford Press (2006) at page *xi*.

[2] *Substance Abuse as a Cross-cutting Issue* by Matthew Greer, National Conference on State Legislatures (November 30, 2006).

[3] *Homelessness in Wyoming,* Wyoming Interagency Council on Homelessness (May 2005).

[4] New York Times newspaper March 13, 2007.

Despite these successes, the challenge presented by the abuse of alcohol and other drugs continues to be daunting and costly. Addiction affects all Americans and virtually all public services.

I want to especially note the partnership we have experienced in Wyoming as Governor Dave Freudenthal, the First Lady, Nancy Freudenthal, and the State legislature have played key roles in providing necessary leadership and resources for treatment. The First Lady has been an especially strong voice raising the level of awareness about the problem of underage drinking. The Governor and the legislature have responded quickly and decisively to the high rates of methamphetamine use in our State.

State funding of treatment and prevention have increased significantly. In 2000, the $2.4 million received by the State in the Substance Abuse Prevention and Treatment Block Grant represented more than one-third of Wyoming's expenditures on treatment and prevention. In fiscal year 2007 the Block Grant's contribution has dropped below 10 percent even though it increased to just over $3.3 million. Our State now funds more than 90 percent of the treatment and prevention costs.

I would like to offer the committee three recommendations. The first involves strategies to replace the myths with the science in order to promote more effective prevention and treatment and more relevant public policy. The second is that Congress give States and local communities the flexibility they need to make the best use of their resources and community leadership to address their own unique substance abuse problem. Finally, I recommend that we stay the course on accountability, recognizing the progress that has been made and working together on a continual quest to improve client outcomes.

MOVING FROM MYTH TO SCIENCE

I am not a clinician nor am I an expert on brain science. I am a systems person which is to say I think in terms of broad systems and how they can interact to achieve certain objectives. Far too often, systems such as the judicial system, child welfare, public benefits, correctional and educational systems operate in isolation from one another. People suffering from addictive disorders, however, live in a different world, one where their use of drugs is a part of a life organized around a combination of experiences. Addicts often exhibit failure in the school system and on the job, in their families, financial dysfunction, encounters with civil and criminal court systems, child abuse and neglect, sexual issues, health problems and more. The world of the addict is one in which systems self-organize and interact negatively around seeking and using drugs. Prevention and treatment efforts are often somewhere else, isolated from the many different systems that comprise the complicated world of addicted persons.

Mr. Chairman, over the last 40 years, I have viewed the substance abuse system from several perspectives. As a State lawmaker for 10 years, as a lawyer practicing family law for 20 years, as a jail and prison chaplain for 5 years, I worked with addicted persons and the programs that serve them in several capacities. However, it was not until I experienced these problems as a parent that I began to study substance abuse enough to ask hard questions like "why do people use drugs when the consequences are so dire?" Because our family had the resources necessary to purchase the best treatment in America, our family member did well and has gone on to enjoy a good life interrupted only briefly by substance abuse.

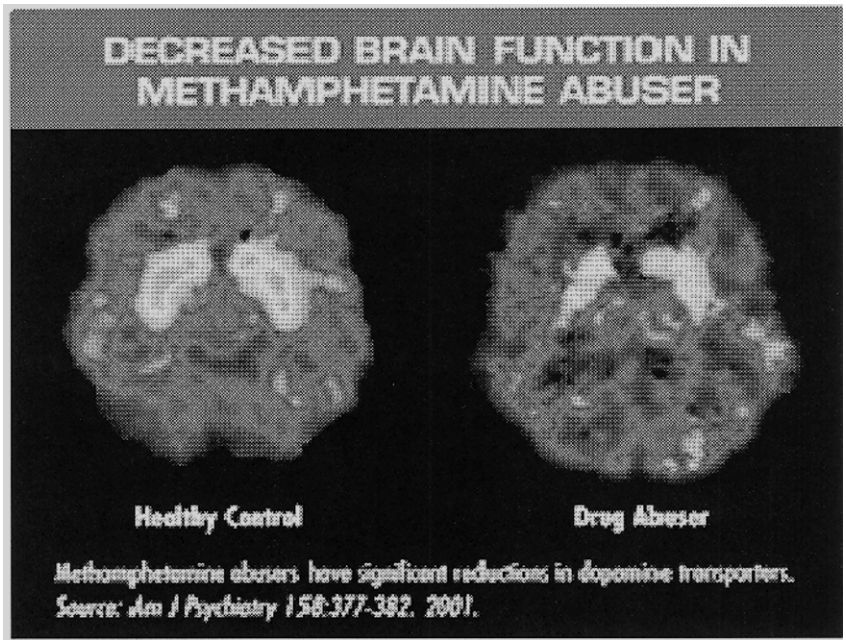
But while that was happening I was serving as a jail chaplain. There I saw countless addicts in the corrections and child welfare systems, continuing to live out actively hopeless lives, getting either no treatment or ineffective treatment. I began to look at the system and to ask questions about the science and what worked and why. In some measure, the difference between those who got help and those who did not were resources. But there was something more troublesome. Operational myths such as "the addict really has to want it before treatment will work" effectively substituted for the responsibility of the system to produce outcomes. Additionally, the known science was either ignored by or not known to many of the clinicians and policymakers whose decisions directly impacted lives.

While many operate on popular notions that addiction is the result of character defects or bad parenting, the science teaches that addiction is a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful, even catastrophic consequences for the addict and those around him or her. An important goal of current neurobiological research is to understand, through the use of various scanning technologies, the neuron-pharmacological and neuron-adaptive mechanisms within specific neuron-circuits that mediate the transition from occasional, controlled drug use to the loss of behavioral control over drug-seeking and drug-taking that defines chronic addiction.

Although significant work remains to be done, we have determined that drug dependence negatively impacts the orbito-frontal cortex rendering the individual to be insensitive to the future consequences of their behavior. The research has identified that part of the brain that is critically involved in the evaluation and inhibition of stimulus-reward associations, emotion processing, and decisionmaking and the regulation of social behavior.

In other words, while the decision to use and abuse drugs is a matter of choice, there comes a time when continued abuse turns on the addiction switch in the brain. That time can vary depending on factors ranging from genetics to environment to type of drug and frequency of use. But it is an actual re-wiring of the brain chemistry that trips that switch. Choice is replaced by a brain-driven compulsivity to use drugs as the addiction literally rewires the brain and "desensitizes" the addict from the consequences of their behavior.

A key SAMHSA goal is to identify ways of bringing this constantly changing and growing neurobiological knowledge to the treatment field in the form of evidence-based practices based on individual need.



(Reprinted from "Drugs, Brains and Behavior: The Science of Addiction', a publication of NIDA, page 19.)

If lawmakers, policymakers, judges, social workers, therapists, parents and others could achieve a common understanding of addiction based on the science, we would be in a far better position to find real solutions.

As I listen to legislative debates, read child welfare caser plans or watch courtroom dramas involving drug use and addiction, I feel at times as though I am watching the six blind men describe the elephant. Everyone is using the same terms; e.g. *addiction, drug abuse, accountability, treatment*. But to each speaker, those words have a different meaning. If you ask the key players in the courtroom or many State legislative committees where they get the information upon which to decide matters of substance abuse, they will repeat the myths, talk about personal life experiences or reference the popular cultural images. Ask them sometime how much of their information actually comes from the scientific literature and the data. In truth many of the players in this arena continue to be guided in whole or in part by the myths instead of the science.

I am often asked, "What is the one thing that could be done to solve the challenges posed by substance abuse and addiction?" I used to caution against looking for a "magic bullet." But I have come to believe there is one thing that would make a huge difference and that is exchanging myth for science in therapy, in courtrooms,

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and in law making. A former colleague of mine in child welfare work called this "the need to update people's stereotypes." Indeed if we could update the stereotypes related to addiction, countless lives and dollars could be saved.

Relying on the myths that have been debunked by good science is not simply a neutral activity. Resorting to myth when science would lead to a better decision is harmful both in terms of wasted lives and wasted dollars. I found a helpful, working definition for the word "myth." Myth is a lesson in story or anecdotal form which has deep explanatory or symbolic resonance for preliterate cultures, who use myths to preserve and cherish the wisdom of their elders."

In the context of substance abuse, the term "preliterate" can be read to refer to those who have not brought recent science to their thinking and practice. In my experience there are at least five such lessons frequently told in story or anecdotal form which have deep explanatory or symbolic resonance for these preliterate cultures who have used these myths to preserve the wisdom of their elders . . . deadly myths which are often at the heart of poor judicial and legislative decisions and harmful therapeutic practices.

1. The myth that "a person has to hit rock bottom before they are ready for treatment." Consider for a moment what that means. It means we watch while the addict both suffers and causes others to suffer. Hitting rock bottom often means the loss of jobs, health, homes and families en route to the bottom where addicts commit crimes, acts of domestic violence and child abuse, where there are victims of their acts and costly criminal processes or oftentimes death. Waiting for an addict to hit rock bottom ignores the fact that there is ample science to permit the use of early intervention. Courts can see the signs of addiction in the persons who appear before them for minor criminal acts. Schools, employers, the faith community and others are aware long before the addict hits rock bottom that a person needs help. The myth about hitting rock bottom is an excuse for doing nothing when it would matter most.

2. The myth that a person "really has to want treatment before it will work" is one that I find especially troubling. One of the most successful interventions, particularly for chronic, serious, high risk addicts is drug court. It is successful for a number of reasons but in general because the drug court judge creates an environment that coerces the addict into disrupting his or her pattern of drug use for a long enough period of time that the addict integrates other, healthier behaviors into his or her lifestyle, eventually replacing drug use altogether. The research is clear that coerced treatment works. Courts are not the only place where coerced treatment can be effective. Employers have great capacity to force addicted employees to make hard choices.

3. The myth that addiction can be resolved by longer and mandatory jail sentences and other penalties such as the loss of student loans or other government benefits. One of Wyoming's outstanding law enforcement professionals is the Chief of Police in Casper. Tom Pagel says it well. Chief Pagel says there are criminals who commit drug crimes for profit and there are drug addicts who commit crimes to feed their addiction. He cautions against treating them all the same in the criminal justice system. When I served as a jail and prison chaplain, I grew weary of watching the offenders and their families walk repeatedly through the revolving jail house doors. Addicts sentenced to longer, even mandatory minimum terms. Families left with children divided among relatives or placed in foster care by a system that knows children who have that experience are considerably more likely to have addiction problems themselves. Part of effective treatment means holding addicts accountable but there is little accountable about spending time in jail without treatment. As the brain imaging clearly demonstrates, addicts have a brain disease and jail sentences, regardless of length, will not change that unless accompanied by effective treatment for the neuron-chemically caused brain damage.

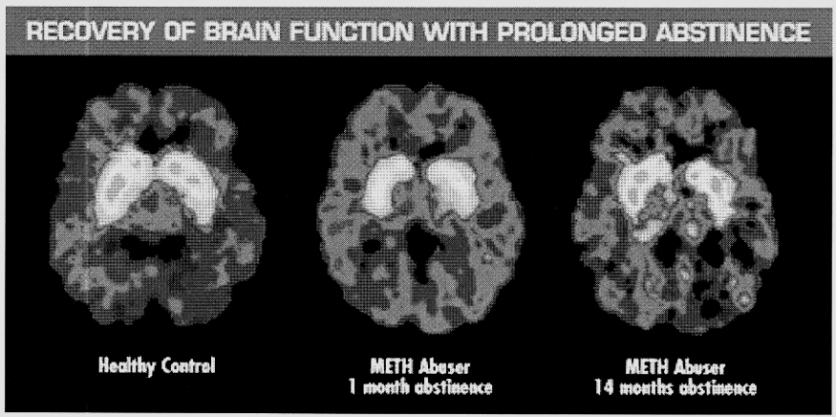
4. The myth that teaches addiction is a character defect exhibited by those who simply refuse to exercise self control. As a young lawyer I knew nothing about the science of addiction. Yet I often represented clients who would be threatened by judges with the loss of their children or with prison sentences if they took one more drink or used drugs one more time. To me, it seemed like a no-brainer. After all who would choose to use again when the consequences were so clearly contrary to their own best interests. But use again most of them did. The science explains the way in which addiction is characterized by the compulsive need to use even though there are such dire consequences. When you look at the brain scans of active addicts, it is clear even to a lay person that the changes wrought by drugs to key parts of the brain are significant. Legislative decisions and judicial practices built around the science of addiction are far different from those built on a belief that addicts should "just say no."

5. The myth that addicts should not use medications because that is "only trading one drug for another." This is among the more discouraging of all myths because I hear it often from certified, trained therapists who would know better if they had updated their own stereotypes for the science. Because addiction is a disease characterized, in part, by relapse, new prescription drugs have been developed that reduce the cravings and, therefore, the risk of relapse. This is an important example of how an understanding of the brain science leads to helpful therapies.

I do want to especially commend the National Institute on Drug Abuse, HBO and the Robert Wood Johnson Foundation for their recent work to make this important knowledge more understandable and accessible to citizens and policymakers alike. NIDA has published a remarkable booklet entitled "Drugs, Brains and Behavior: The Science of Addiction." It is an inviting, informative, reader friendly work that joins the HBO/Robert Wood Johnson film documentary entitled "ADDICTION" as two of the most important public efforts in recent years to change the thinking on this critical issue.

The key to developing effective public policy as well as effective treatment and prevention is the ability to articulate the changes in the brain's reward system is the cornerstone. I am not an expert on the working of the brain but I do not think policymakers need to be if they can grasp the basic concepts. I have read books and listened to presentations that make all of this very complicated. I have also heard lay persons describe the neurobiology of addiction in a way that I can understand.

My first exposure to the brain science came during a methamphetamine conference in Walla Walla, Washington. I was seated with a group of Washington State legislators one of whom was a member of their Appropriations Committee. We watched a presentation that included slides of brain scans showing the progression from non-use to abuse to addiction and on to treatment and recovery. Especially informative are the brain scans of those persons who are fully and actively addicted. Even a lay person can see that in key parts of the brain where we make decisions and exercise judgment, the lights are off. Yet this is the picture of the brain of those who enter treatment. The Washington legislator looked at that slide and said, "Ah ha . . . so that's why our 28-day programs don't work!"



(Reprinted from "Drugs, Brains and Behavior: The Science of Addiction', a publication of NIDA, page 25. Attachment B is a larger image of this brain scan.)

The slide supports other conclusions as well such as why typical probation programs do not work as well as fully supervised drug courts and why the 15/22 rule of the Adoption and Safe Families Act can be an effective tool in coercing addicted parents into treatment and recovery if better understood by social workers and judges.

It is helpful of course that scientists and researchers have come to understand the way in which increasing, continuous drug use paves the way in the brain for addiction by altering the reward system but what is critical is that lawmakers, judges, social workers and probation officers have a working knowledge of this information. Knowing that chronic drug use lowers the threshold of the brain's reward system and that withdrawal raises that threshold is information that should be used to design probation programs and clinical practices.

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I would encourage Members of Congress to consider using the reauthorization of SAMHSA as an opportunity to explore strategies for expanding the knowledge of addiction-related brain neuron-chemistry to those on the front lines, e.g. judges, social workers, corrections officials, therapeutic community and others working directly with addicts and their families. Unless those in the trenches are provided a basis for understanding this science, it will be many more decades and countless millions of lost lives and dollars before the science is integrated enough in the actual work of these systems to make a difference.

In fact, SAMHSA already has two important structures designed to infuse the latest science into our service systems: the Addiction Technology Transfer Centers (ATTCs) and Centers for the Application of Prevention Technologies (CAPTs). These regional entities, located throughout the United States, work to translate the latest substance abuse science in order to create learning opportunities to improve the practices of States, counselors, prevention professionals and community coalition members. The CAPTs and ATTCs sponsor regional conferences, workshops, and training of the trainer events regarding evidence-based practices, provide customized technical assistance, develop training curricula and products, and create online courses and classes. Unfortunately, the ATTC's and CAPTs are under-funded, with the proposed fiscal year 2008 budget seeking to eliminate funding for the CAPTs altogether.

These strategies should be pursued even as additional funding is provided to expand the brain and genetics research related to addiction disorders. But it is not enough that a select group of scientists are aware of the genetic impacts on brain development leading to addiction. The development of the science must be accompanied by a diffusion of the knowledge so that it can replace the myths that too often drive therapeutic practices and public policy choices. NIDA and other researchers knowing that brain development makes some folks more susceptible to addiction than others and that the reward circuitry of the brain may control one's reaction to chronic drug use . . . is important but it is not sufficient. It is when I start to hear discussions of the way in which chronic drug use changes the brain in the coffee shops around rural Wyoming, that I will know we have a winning strategy.

SYSTEMS IMPROVEMENT THROUGH FLEXIBLE FUNDING

Providing effective treatment and making good public policy also requires a recognition of the fact that drug use is generally experienced as a part of a larger universe of social problems. Drug use is usually accompanied by school failure, mental health issues, family dysfunction, domestic violence, problems with health, housing, jobs, child behavior and more.

People who chronically use drugs en route to addiction are frequently clients of the correctional, public welfare or child welfare systems. They come to the early attention of lower level criminal courts. Some are chronically homeless or out of work. As a result, addicts and chronic drug abusers fill the ranks of the clients of a variety of public service systems. Therefore, neither prevention nor treatment should be an endeavor isolated to a group of the usual suspects.

SAMHSA has been especially cognizant of the systems issue. Sponsoring training opportunities such as the June 2007 conference entitled "Achieving Common Goals" bringing together relevant agencies to discuss innovative ways to address common client problems is an example of their responsiveness.

It is equally true that the problems presented by drug abuse are different in different communities. For example, the 2005 Youth Risk Behavior Survey concluded that while 8.5 percent of high school students had tried methamphetamine during their lifetime, 77 percent had already used alcohol. A 2005 survey of law enforcement officials disclosed that in 10 of Wyoming's 23 counties, 59 percent of all arrests involved alcohol.

A number of Wyoming communities are experiencing high rates of meth use. Even more have continued to experience high rates of alcohol abuse. In others, there is a growing concern about prescription drugs. States and communities need flexible funding streams that allow them to address their unique substance abuse challenges.

Virtually all of the "systems" necessary to comprehensively treat and prevent substance abuse are local systems. They include the local court system, a local public and private treatment provider system, local child welfare system, local schools, public health, housing, business and faith communities and family systems. Systems improvement is vital to positive outcomes for addicted persons. While the Federal and State governments can encourage local systems improvement, it will actually happen only through the empowerment of local community leadership.

Accordingly, my State and others would benefit from a flexible funding approach giving States room to navigate through their unique drug problems, their unique political and economic systems, their unique geography, and their unique set of resources.

Wyoming's drug court program is an example of the sort of flexibility that allows funds to be used creatively in different communities to achieve broad common goals. The State legislature has provided funding within a framework that requires local drug courts to use the 10 components of an effective drug court. Beyond that, local communities and courts may decide how to use the State funding to meet local needs. In some communities there is a priority for adult felony courts, in others the need is for juvenile courts, or family treatment of DUI courts. A critical ingredient of the success has been the fact that the legislature has provided for coordination of the program through the office of the single State authority.

Another example of our approach to systems improvement coupled with flexibility is our new contracts with substance abuse providers. Each public treatment provider is now being asked to enter into a memorandum of understanding with their local child welfare, public welfare and corrections systems to create a shared set of goals and practices to assure effective treatment of common clients across their systems. At the end of this process, we expect there will effectively be a single system, single case plan, and single set of shared values that persons who need services will experience when they walk through anyone of those doors with a mental health or substance abuse problem.

This flexibility should be applied to the Substance Abuse Prevention and Treatment Block Grant which has been an effective and efficient funding stream to support vital services to Wyoming citizens. The drug problem is much more a community problem than a national problem. No one has more at stake in meeting the challenge than the neighbors of those who are addicted and their families. No one has more to lose or more to gain than the folks who live in the community or the neighborhood where drug use causes chaos. Given flexibility, these community leaders will make the right choices.

ACCOUNTABILITY

I am comfortable that I speak for all State administrators when I say we are as concerned as any Member of Congress about the accountability of all of us to produce good outcomes.

Wyoming has experienced technical problems in getting its system on line but we are there now and so is nearly every other State. I believe the States, working with SAMHSA and NASADAD, have made excellent progress on the establishment of the National Outcome Measures. I especially want to recognize the hard work of our Governor and the Wyoming Legislature in demanding outcome data as they have supported greater investments in the treatment system.

NASADAD can tell you more about the other States but in Wyoming the legislature has enacted statutory requirements that the Department of Health use outcome measures for treatment programs. We are using the National Outcome Measures (NOMS). The legislature further enacted a measure requiring that I, as the SSA, withhold funds from all provider contracts until and unless we have a written agreement on measuring outcomes. Finally, the Governor and the legislature have demanded that our system measure outcome data across agency systems in order to broadly assess outcomes on a longitudinal basis.

The provider community has stepped up and agreed to measure outcomes based on the NOMS. Our contracts require each provider to report NOMS quarterly on all clients. As this data accumulates, we will be in a better position to improve services, identify best practices in our rural State and to inform policymakers as they grapple with funding and legislative decisions.

Wyoming and other States are fully committed to NOMS reporting. Yet I do want to express concern about a fiscal year 2008 budget proposal to penalize 5 percent of the Substance Abuse Prevention and Treatment Block Grant for those States that are unable to report NOMS by the end of this year. If we are unable to do so, and I do not currently expect that to be the case, it will not be because of any reluctance to do so on the part of the State agency or the providers. It would result from gaps in our data infrastructure and the ongoing technical challenges of effectively integrating data collection and reporting technologies.

I agree with NASADAD that providing positive incentives is better and more effective public policy than imposing block grant reductions that will directly impact our ability to provide necessary treatment and prevention services to citizens.

Additionally, we are exploring the use of a process similar to the Children and Family Services Reviews under the Adoption and Safe Families Act. Under that

process every State child welfare system is evaluated using a common tool to determine the extent to which the States are meeting the safety, well-being and permanency needs of children in State care.

One of the tools used to improve performance of the child welfare system is the Citizen Review Panel enabling consumers and other citizens, along with child welfare professionals to actually participate in case reviews in order to have the sort of transparency that actually improves systems. We are considering a process that would mimic that same consumer centered process in order to review treatment practices for the purpose of enhancing accountability by making the substance abuse treatment system less mysterious and more transparent.

CONCLUSION

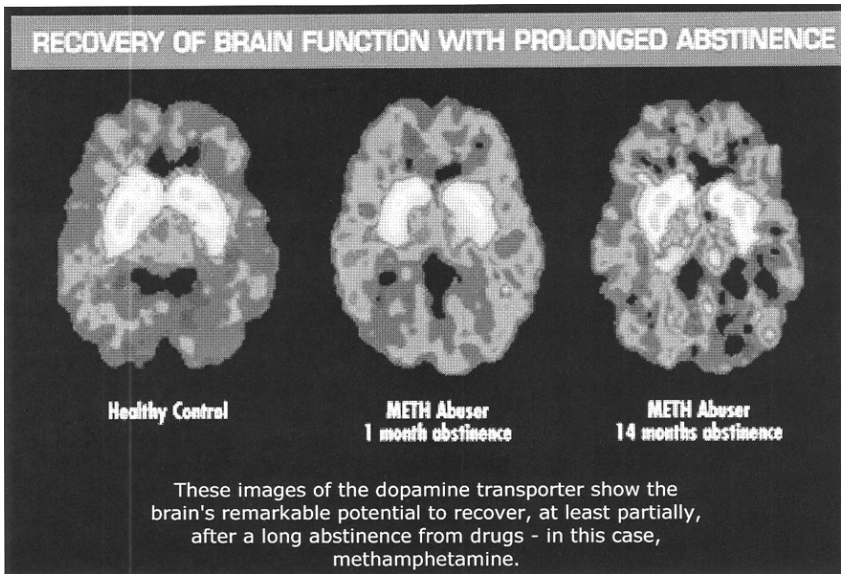
Thank you for this opportunity to appear before your committee and to offer my views on the important work before you. Please know that the Office of Wyoming Governor Dave Freudenthal and the Wyoming Department of Health welcomes any opportunity to be of assistance in your work. Additionally, NASADAD stands ready to support and work with this committee on issues related to substance abuse and mental health—including SAMHSA reauthorization. NASADAD's expertise and commitment to improve service delivery represents a wonderful resource.

ATTACHMENT A

Wyoming Substance Abuse Prevention and Treatment Block Grant Awards

Federal Year	SAPT Award [in millions of dollars]	State Year	State Funding [in millions of dollars]	Total Funding [in millions of dollars]	SAPT Funding [in percent]	State Funding [in percent]
FY 2007	$3,305,977	SFY-2008	$30,965,682	$34,271,659	9.65	90.35
FY 2006	3,299,412	SFY-2007	23,293,913	26,593,325	12.41	87.59
FY 2005	3,333,448	SFY-2006	19,753,778	23,087,226	14.44	85.56
FY 2004	3,333,335	SFY-2005	15,466,986	18,800,321	17.73	82.27
FY 2003	3,193,795	SFY-2004	15,393,328	18,587,123	17.18	82.82
FY 2002	3,048,693	SFY-2003	15,209,480	18,258,173	16.70	83.30
FY 2001	2,751,260	SFY-2002	8,303,744	11,055,004	24.89	75.11
FY 2000	2,452,377	SFY-2001	4,755,678	7,208,055	34.02	65.98

ATTACHMENT B



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Senator REED. Thank you very much, Mr. McDaniel.

Mr. Allebaugh.

STATEMENT OF TERRY LEE ALLEBAUGH, EXECUTIVE DIRECTOR, HOUSING FOR NEW HOPE, INC., DURHAM, NORTH CAROLINA

Mr. ALLEBAUGH. Thank you, Senator Reed.

My name is Terry Allebaugh and I'm the founding director of Housing for New Hope, a nonprofit organization rendering services and building housing for the homeless in Durham, North Carolina.

I'm joined here this morning by Alfonso Williams, a formerly homeless man, who's now serving as our Program Director for one of our transitional housing programs.

Two years ago, my organization began outreaching through our P.A.T.H. program to two valuable men who are living in Durham. The men were living in a makeshift tent in a narrow strip of woods between Main Street and the railroad tracks near a thriving area of Durham called Lane Street. Being also near Duke University, the area provided a fertile ground for the men's panhandling efforts.

We suspected immediately upon outreach, that one man, who was called "Concrete" because of the seemingly resilience to the harshness of living year round outside, was schizophrenic. We also believed that the other, called White Mike for what I think is probably obvious reasons, suffered from—was clinically depressed. Both men were self-medicating with alcohol, both men had given up hope that anything else was possible for them in their lives.

For our first year, we visited and talked with them, we took them sleeping bags, we'd take them occasional food, we'd take the toiletries, and they graciously accepted our gifts, and they would also continuously decline our engagement to see service providers and to go into housing. They had given up hope that anything else could be possible for them.

The business owners in the community around begrudgingly accepted their presence and said pretty much, "Well, you know what? Some people just choose to be homeless. What can you do?"

Then White Mike's health status grew worse as his exposure to all the elements continued and he was transported twice by a rescue squad to the emergency room where he was hospitalized for internal bleeding. Soon Concrete moved out of the tent and he was found sleeping at night, soon afterwards, behind the bike rack at Kinko's.

Unfortunately, these stories of Concrete and Mike are not unique. They are only two of 744,313 in our country each night who are homeless. They are only two of the 11,165 people in North Carolina, and only two of the 539 counted in Durham. Both the despairing homeless and the confused citizenry are looking to us here in this room for leadership, commitment, and increased funding to improve services.

Through our work, Housing for New Hope has come to believe one thing. And if you remember nothing else from my testimony, I hope it's this. No one, nobody, not at any time, chooses to be homeless. There are plenty of people, however, that have settled for homelessness. They have settled for that because they have given

up hope that those services which will help them best, that housing which they can afford and is tailored to their needs, will provide a solution to their homelessness. Piecemeal services, congregate shelters, and spare change do not lead to transforming these systems of care.

Homeless people, especially those with disabling conditions, need real services that are comprehensive. They need real homes where their name is on a lease and they have rights and responsibilities. They need real change, not spare change.

Data collected nationwide reveals that 23 percent of our homeless in this country are chronically so, meaning that they've been out there for a long time. They are there because they are poor, and they lack the financial access to housing and services. The longer they remain homeless, the more debilitating their chronic conditions become. Additionally, the more expensive their treatment and response to them becomes for our systems.

As you probably know, many of the chronically homeless, as with these gentlemen, seek healthcare from emergency rooms, where they're transported by a rescue squad. They're temporarily housed in our jails and prisons, and they seek periodic help for mental and primary health in hospitals for chronic health conditions. We can no longer fool ourselves that by providing minimal support to this population, that we're saving our tax dollars.

Housing and Urban Development has been stepping up to the plate in the area of permanent housing. They are providing resources and require that folks build permanent housing if they're going to receive HUD funding.

I'm here today mainly to encourage you all to include a part of a bill that's called SELHA, which is Services to End Long-Term Homelessness Act. It was introduced by our North Carolina Senator Burr and co-sponsored by Senator Reed, into the SAMHSA funding. Put SELHA in SAMHSA and this will make a difference for us, where we have housing, we have P.A.T.H. programs, but we do not have the ongoing clinical support the people need in our communities.

We did visit Mike when he was in the hospital—just a few minutes, and I'll finish this part of the story, Senator Reed, if that's okay—and he did decide to go into treatment, and he did decide to enter our transitional housing program and he's now living in one of our efficiency apartments where he's working at his job. He's actually started doing outreach on the P.A.T.H. team. Concrete committed himself to a hospital, mental health hospital for 7 days. He was released with 7 days of medication, given the name of a service provider. He disappeared for a while and he has now reappeared, sleeping behind the bike rack at Kinko's. I think we can all work together to do better for Concrete and also to make sure we prevent, so that Mike and Concrete and others like him around the country are not left out there.

Thank you.

[The prepared statement of Mr. Allebaugh follows:]

PREPARED STATEMENT OF TERRY ALLEBAUGH

My name is Terry Allebaugh and I am the founding director of Housing for New Hope, a 15-year-old nonprofit organization rendering services and building housing

for the homeless in Durham, North Carolina. At Housing for New Hope, we work to prevent and end homelessness one valuable person at a time.

Two years ago, we began outreaching to two such valuable men through our P.A.T.H. program (Projects for Assistance in Transition from Homelessness, administered by SAMHSA). The men were living in a makeshift tent in a narrow strip of woods between Main Street and the railroad tracks near a thriving area of Durham, called 9th Street. Being also near Duke University, the area provided a fertile ground for the duo's panhandling endeavors. We suspected immediately, and it was later confirmed by psychological testing that "Concrete", so named because of his seeming resilience to the harshness of year-round street living, suffered from schizophrenia, and "White Mike," so named for obvious reasons, was clinically depressed. Neither man was receiving treatment and both were self-medicating with alcohol. Both men had given up hope that there could be something different in their lives.

For over a year we visited and talked with them at their tent or on 9th Street. They always thanked us for visiting and graciously received our periodic gifts of sleeping bags, blankets, toiletries, and food. They also repeatedly declined our offers to connect them to services, housing, and hope for tomorrow. The business owners and their patrons begrudgingly accepted them, with a few exceptions, and most everybody seemed resigned to the fact that well, "some folks just choose to be homeless."

Then "White Mike's" health status grew worse as his exposure to all the elements continued, and twice he was transported via rescue squad to the emergency room, and then hospitalized for internal bleeding. Soon, "Concrete" moved out of the tent and was found sleeping at night behind the bicycle racks outside Kinko's on 9th Street.

Unfortunately, the stories of Mike and Concrete are not unique.

They are only two of the 744,313 homeless people in the country on any given night who are looking to us, here in this room, for real change by ensuring access to mental health services and affordable housing. They are two of the 11,165 on a given night in North Carolina, and two of the 539 counted in Durham. Both the despairing homeless and the confused citizenry are looking to us for leadership, commitment, and increased funding leading to improved services.

Through our work, Housing for New Hope has come to believe that nobody chooses to be homeless. Some people settle for homelessness because they have given up hope that anything else is possible. *Piecemeal services, congregate shelters, and spare change do not lead to transformative systems of care*. Homeless people, especially those with disabling conditions such as mental illness, substance addiction, and poor physical health need real services that are comprehensive. They need real homes where they are leaseholders with rights and responsibilities. They need real change, not spare change handed out by those more privileged who themselves are looking for a temporary fix for their guilty feelings.

Data collected nationwide reveals that 23 percent of the homeless population are chronically homeless, meaning they have been living on the streets with disabling conditions for long periods of time. They are there because they are poor and lack access to needed health care systems and affordable housing. The longer they remain homeless, the more chronic and debilitating their health conditions become and the more expensive our piecemeal, temporary, and spare change services cost us. Many of the chronically homeless receive their primary health care in the emergency rooms and are transported there by a rescue squad. They are housed periodically in jails and prisons, transported by law enforcement officers, and adjudicated by the courts and court-appointed attorneys. They are frequent, short-term visitors to primary and mental health hospitals with high per diem rates for the doctors, nurses, and tests.

We can no longer fool ourselves that we are being frugal and prudent with our tax dollars by only giving minimal attention to the chronically homeless population.

Housing and Urban Development (HUD) has been stepping up to the plate in the area of permanent housing and chronic homelessness by requiring that at least 30 percent of all funds awarded nationwide through the Supportive Housing Program be for the creation and provision of permanent housing. Additionally, HUD makes a bonus award available for each community that targets permanent housing projects for the chronically homeless. My own organization, Housing for New Hope, has 40 units of permanent housing partially funded by three HUD grants, and we have just been awarded a capital grant for the construction of another 10 unit apartment building to house the chronically homeless.

However, HUD has made clear that they intend to fund what they do best, namely housing, and that we cannot look to them for the provision of service dollars. We need SAMSHA to step up to the plate and provide the core service dollars that will make the housing dollars more effective in our communities.

In a report produced by the U.S. Department of Health and Human Services entitled, *"Ending Chronic Homelessness: Strategies for Action,"* the authors concluded that no mainstream program is comprehensive enough to adequately serve chronically homeless people. Therefore, agency budgets need to target dollars to this population. In a bill called Services for Ending Long-term Homelessness Act (SELHA) that was introduced and championed by our North Carolina Senator Richard Burr, and was co-sponsored by Senator Jack Reed and others, there is a detailed plan for needed services for this population that can be coordinated with other systems that are delivering housing, jobs, and primary health. The bill provides mental health and substance abuse treatment as well as health education and recovery activities. I strongly encourage you to increase funding within the current homeless programs by $80 million and include the goals and funding for SELHA in the reauthorization of SAMHSA.

It's easy to remember: put SELHA in SAMHSA.

I can tell you unequivocally that the main ingredient currently missing in our work to end and prevent homelessness in Durham for the chronically homeless is mental health and substance abuse services. Our P.A.T.H. program is doing remarkably well to outreach and engage, and is making some incredible things happen. With the help of HUD and our city and State governments, we are putting housing on the ground. However, without the presence of clinical teams who are trained, committed, and dedicated to the issues confronted by the chronically homeless, we, like many others around the country, are part of the piecemeal, spare change system of care.

Our Local Management Entity, The Durham Center, and our State level Department of Health and Human Services are working hard in a tough environment to squeeze out a few dollars to target resources in this area. However, they need SAMHSA's help in order to make real and substantial change that will create the necessary infrastructure and coordination of social services.

There is an amazing thing happening in our country right now. Business leaders and folks from congregations, people in nonprofit and government agencies are working together like never before to implement strategies that will end homelessness as a statistical reality in our country. Major cities are reporting significant decreases in the number of homeless people living on the street. But there are many miles to travel before we reach our goal.

Along the way, we will keep reaching for our goal one valuable person at a time.

Our team visited Mike while he was hospitalized, and he decided to seek substance abuse treatment. Then, he decided to come into one of our transitional housing programs. Then he moved into one of our efficiency apartments where he pays his rent, works his job, and has started working on our P.A.T.H. outreach team as a peer specialist. What a distance he has traveled—from living in the woods with no access to the mental health care that he needed, to living in his own place, helping others access the services they need to regain their hope for a better life.

Concrete recently committed himself to mental health hospitalization. He was there for a few weeks, given a 7-day supply of medication, an outpatient referral slip to a mental health provider, and released. He disappeared, but recently reappeared on 9th Street. He has run out of medication, has never seen the provider, is back to being mistrustful of help, and is sleeping behind the bike rack.

I don't think you, or I, are comfortable leaving him out there.

We know what it will take to bring "Concrete" and others like him into housing and services. We know what it will take to prevent Mike and Concrete from being out there all those years. I urge you to include SELHA within the SAMSHA reauthorization to allow us to provide the services that will give hope, opportunity and stability to our citizens who have so little.

Thank you.

Senator REED. Thank you very much, I want to thank the panel for the excellent testimony, and let me say how pleased I am to be working with Senator Burr on this issue of providing services to the homeless. I think Rich and I share the same sense of frustration, that we spend money on housing, but without these services, it seems to be not adequately utilized. Might you want to comment on that, Mr. Allebaugh?

Mr. ALLEBAUGH. Well, I think we are fortunate that HUD has stepped up and is providing some funding in this area, but if people don't receive the supportive services that they need for recovery, as you've heard many of the other people testify here today, the hous-

ing tends to be short-lived. And so, we have found that true in Durham, and I'm sure they're—and from what I hear they're finding out around the country.

So, it's an important effort to complement, where there's already some initiative happening.

Senator REED. I think your testimony makes the point, this is not just a "big city" phenomenon, this is everywhere in the country, and you also, I think, make an excellent point that if you look at the cost of homelessness, emergency room treatment, incarceration, it far exceeds the cost of treatment, we just have to make sure we get the numbers right, and do it right.

Mr. ALLEBAUGH. Well, as Senator Burr mentioned in his opening statements, Portland has done enough now that they have some comparative costs that show that they're saving about $16,000 per person, per year, providing this type of housing, instead of allowing people to continue to cycle through our various systems.

Senator REED. Just one other question, Mr. Allebaugh, and again, let me commend you for your great work. What proportion of your population are veterans who served the country, and now are on the streets?

Mr. ALLEBAUGH. We typically run about 15 to 20 percent of our population in Durham, are homeless Veterans.

Senator REED. And that is a sad commentary for individuals who have served their country.

Mr. ALLEBAUGH. It is, and we try to take advantage of every opportunity of funding that targets that population.

Senator REED. Thanks, so much.

Lisa, let me thank you for your excellent testimony, and for the courageous example that you've shown, not only in moving forward in your life, but helping so many others. Could you elaborate on what you found most helpful in your recovery, please?

Ms. HALPERN. I would say accommodations and high expectations, the two together. In my return to graduate school, I received accommodations to help me further my education. For example, extra time on tests, and being in a different, quiet room during tests, because the sound of a pencil is too much stimuli for me to listen to.

And the other critical piece to my recovery, and my ongoing recovery has been the high expectations of my family, and the high expectations of my doctor. Before I could read and write, my doctor believed that I was going back to Harvard. And it was just a simple question of how do we get from A to B? And, my family's been a terrific support, as well, so it's—I've been very fortunate, in some ways, I've been blessed, so——

Senator REED. Well, one of the things you've just mentioned is the flexibility of being able to take time off and having a support system, but I would imagine that's not the case in all of the people you work with?

Ms. HALPERN. Right.

Senator REED. And, that's something we should probably think about in terms of how we structure our programs, is there any advice you might give us?

Ms. HALPERN. The program that I work for in Dorchester, the population is men with substance abuse and mental health con-

cerns and worries, and that population is different in its needs and abilities and aptitudes than what another population might be, so I think what I've learned from working on the P.A.T.H. team at Westbridge is a strength-based approach, where you meet everyone where they are, and that's what I try to do when I'm on the peer counseling side of things, is to meet people where they are, and accentuate their strengths.

Senator REED. Well, thank you very much, Lisa, again for your great testimony and for your great work.

Mr. McDaniel, you have an array of perspectives—you're a lawyer, and a minister and an administrator, and thank you for bringing along the scientific evidence that should be underlying all of our decisions.

I wonder if you might comment on, SAMHSA basically has two block grant streams, the substance abuse and the mental health, and everyone has concluded that it has to be coordinated. From a State level, do you have any specific advice how we might do that, and in addition, coordinate with the larger medical community?

Mr. DANIEL. Mr. Chairman, in particular, the latter part of your question is, I think, very important. Because I think one of the real issues in mental health and substance abuse is the extent to which mental health and substance abuse services have been isolated from primary care, and even to the extent of those services taking part in another part of time, and we see that impacting the workforce as well as front-line services.

Mr. Chairman, I know there's been some discussion about merging the two block grants, I guess I would conclude that that's not a particularly important thing to do. I think in terms of what happens on the ground, in the States, when the block grants flow through to services, that the States are probably the best place to figure out how to funnel those moneys together.

In Wyoming, we've worked with SAMHSA for the last couple of years to assess our services for the co-occurring population, for example, and how to merge services and funding streams in order to accomplish that. And, I think at the State level, people can generally figure out how to do that.

In 1999, the then-Governor of Wyoming chose to divide substance abuse from mental health, because substance abuse needed a greater priority. This Governor, this year, has chosen to re-integrate mental health and substance abuse administratively, in order to eliminate some of the silos that had grown up around the separation of the two programs. So, I think, at the State level, and even more particularly, at the community level, those who are involved in delivering the services—practitioners as well as policymakers—can figure out how to integrate those funding streams, so long as the Federal legislation is flexible enough to allow them to do that.

Senator REED. And just a brief comment, if you might, in terms of outcome measurement. Because, you're down there where the outcomes have to be measured.

Mr. DANIEL. Well, Mr. Chairman, it's a critical issue with us. I spent the last 4 years as the head of the State Child Welfare Agency where we experienced, as a result of the Adoption and Safe Families Act, and the Citizen and Family Reviews, that experience

of having a Federal review drive us toward a strategy where data became the way in which we changed services.

I believe we'll accomplish the same thing in substance abuse and mental health working with SAMHSA and NASADAD and others on the National Outcome Measures. When communities see the data, when providers see their outcome data, they'll figure out the strategies that need to work.

I don't believe that any State is dragging its feet on National Outcome Measures, I believe—I know there's a budget proposal that would penalize the block grant 5 percent for those States who don't measure outcomes, I would urge that that not happen, because I—to the extent that there are problems, from my experience, there really are problems in information technology and trying to figure out how to make the systems compatible with the myriad of provider systems that are used to report—that's the struggle we've had in Wyoming. Neither the providers, nor the State policymakers are dragging their feet on reporting the measures, they want that done, it's a significant strategy for improving services.

Senator REED. Thank you very much, thank you all.

Senator Burr.

Senator BURR. Thank you, Mr. Chairman.

Lisa, thank you for that very personal testimony, and on behalf of the organization as well.

Roger, it's not easy to talk about personal experiences, especially when they affect your family, and we appreciate you doing that. And, I'm particularly thankful to you for continuing to mention outcome, because in this town, we don't hear "outcome" we hear "process" and that's disturbing to me.

Terry, thank you for Mike's and Concrete's story. And, you know, the great thing is, in Durham, North Carolina, you've got a long list of names of lives that you've affected. Some of them, not with the word permanently. And that's the tough thing. That's the gap that, I know you know is out there. And, my question to you is quite simple—can the word "permanent" really go in front of this population of homeless, homelessness, without those services wrapped around it?

Mr. ALLEBAUGH. I think it's real important that we are focusing on permanent housing, it is an outcome that we can measure, as we've heard here today, and I think that the provision of permanent housing provides a good base for someone to make changes in their lives as we all use our homes as a place where we attain our self-esteem, our sense of self-worth, our sense of purpose. With the chronically homeless, when they have a disabling condition, permanent housing, to have them in there is the start. It gives them a place where they know they're going to be the next day and the next day, it delineates rights and responsibilities that they have as a leaseholder there.

However, they can not sustain that unless there's support for them in their ongoing process of recovery. Whether that's from substance abuse, mental illness, or recovery from physical health, so unless that complements that housing, we will find that our numbers, as they go down, they'll go back up. And so, we cannot fool ourselves into thinking that any one piece of that is enough.

It is important that the services be distinct from the housing. They're there as leaseholders, they're there in permanent housing, and our service provision needs to be enticing, engaging, assertive—it doesn't need to be required, if you don't attend a meeting, you don't get put out of your housing, that's not a good practice, it's a bad practice.

But, it is important that we have services that are constantly engaging. And what I have found that people who are homeless need above everything else, is a chance to participate in a community, to see their individual lives as part of the larger whole, and to have the ability to contribute back to that. And, I think permanent housing, with supportive services, gives the individuals that opportunity, and thus makes our communities better places to live.

Senator BURR. Well, I think it's safe to say that Jack and I understand the cost argument that you made, which is very compelling. Unfortunately, in Washington, there is no dynamic scoring, so we don't get this benefit of being able to go out and prove how much money we save, by going out and spending money, which is insane. And, I'm proud to say that many members on this committee get it, and they don't let that be a limitation. So, I think—my hope is that we will do some things out of the box, we will find some ways to get new moneys so that services can be provided, and you can have more people with "permanent" in front of it.

And Roger, you highlighted the importance of basing substance abuse treatment on brain science research evidence. Let me ask you, specifically—how can SAMHSA coordinate, or how can SAMHSA contribute to developing and disseminating this evidence?

Mr. DANIEL. Mr. Chairman, Senator Burr, thank you for that question.

I think SAMHSA is doing a lot of that through the Addiction Technology Transfer Centers, and I think additional funding, perhaps, for that process would be very helpful. But, I think there are other strategies, as well, that are probably outside of SAMHSA.

In our State and many other States, the key people that make this work, are usually judges. Many times, lower-level judges. In the context of drug courts, and Wyoming now has 25 very successful drug courts—you have teams of people, including judges, who exercise the judicial leadership in bringing together the prosecutors and the defense bar and the treatment community and housing and education and the others, around the science of addiction. And their outcomes are so significantly better than what occurs in other contexts in the court room, where particularly in the lower-level courts, drug offenders are usually, initially found,—that—I think the lesson drawn from the drug court experience would be very important to the committee. It's a part of that whole process thing where unless the addiction is treated with a comprehensive approach, then what will happen is that those offenders who are in municipal court, graduate to the District Court and the Federal court on more serious charges.

And so, earlier interventions are important, but somehow, I think, we have to do better in both the medical schools and the law schools in making that a part of the curriculum, so that lawyers who graduate from law school, and doctors coming out of medical

schools, have that integrated in the view of the people that they will help.

Senator BURR. Good point.

Final question, Lisa, what service, education, programs are needed for us to make sure that individuals with a mental illness actually take medication? The medications, as you know, change significantly, almost yearly. And one of the biggest challenges is, those individuals that are afflicted, many times, go off their medications. Then you start back at square one. Is there anything that we can do, that we're not doing today, that would help alleviate that challenge?

Ms. HALPERN. Tough question, Senator Burr.

I would have to say that the most important aspect of trying to encourage one to take medication would be an alliance between the medical provider—whether it's a psychiatrist, or a therapist, or whoever the key provider is—there needs to be an alliance between the individual with illness, and the doctor. And that alliance is sort of a conundrum—how do you build trust with one who does not trust? With a lot of these illnesses, with psychosis, with schizophrenia, there's a basis for a distrust. So, trust has to be built up in order to get an individual to take medication. And sometimes that takes time, it takes time that emergency room doctors may not have the luxury of having. But, if possible, sometimes just having time to form a relationship between patient and doctor is, I think, the most secure way to our indirectly getting to the endpoint of someone wanting to take their medication, because it's the combination of pills that makes them feel well.

Senator BURR. Well, I thank you for that.

And, Mr. Chairman, I think it's something that we already know, is that many Americans don't have a relationship with a healthcare professional, at all. And, you're right, the emergency room is not the model of primary care delivery, it's a model of trauma, and it has now really become a facility that provides every type of health care imaginable. And some, they do well, and some they don't do very well at all. But, it sort of puts us back in the mode that we have a health care system that's designed only to trigger when you get sick. It's not triggered to keep people well, it's not triggered to do prevention. And the only way that we will change it is if we start up here, restructuring the health care model in this country, so that it promotes wellness, it promotes prevention, and part of that is paying for wellness and prevention and establishing a relationship between a patient, and a healthcare professional, so that they begin to build that trust with somebody in the healthcare community. So, we thank you for that.

Thank you, Mr. Chairman.

Senator REED. Thank you, Senator Burr.

I want to thank the witnesses, all of the witnesses, for an excellent hearing. It strikes me that the themes that Congressman Kennedy outlined initially, evidence-based programs, and Mr. McDaniel has pointed out very graphically how important these programs are, and then coordination, between substance abuse, mental health, the larger medical community, the legal system, the housing community—we have to enhance that coordination, and that means information systems that are reliable, outcomes that

we can measure. It means enhanced training for many participants, both in the legal profession, the medical profession, the substance abuse profession as well as the mental health profession. And, the goal is to provide the programs that will provide adequate treatment, and also, we hope, prevention.

So, I thank you, we've learned a lot, I have, and I thank you all. The committee record will be open for 14 days to allow others who wish to submit written statements to do so, and also to allow my colleagues on the committee who might have follow up questions to address them to the witnesses.

Thank you very much, and the hearing stands adjourned.

[Additional material follows.]

ADDITIONAL MATERIAL

RESPONSE TO QUESTIONS OF SENATOR ENZI BY LISA HALPERN

Question 1. In your testimony you said that the mental health care system is "in trouble." What specifically is broken with the system? Is it lack of funding, to many hurdles, too much bureaucracy, etc.? Why are so many States doing so poorly?

Answer 1. As both the 2003 White House New Freedom Initiative Mental Health Commission report and NAMI's 2006 Grading the States report found, the Nation's public mental health system is plagued by fragmentation and lack of coordination. While a lack of available resources is a problem in many States, in many others it is failure to properly invest in evidence-based treatment models that maximize opportunities for recovery. The reality is that the array of services that adults with mental illness need—medication, case management, housing, income supports, employment, etc.—are spread across multiple service systems, with very little coordination.

The poor performance of State systems—27 States in the NAMI report received a grade of either D or F—is based largely on the absence of comprehensive supports and services that are oriented toward recovery. At the same time, there are many pockets of innovation across the country, including supportive housing, jail diversion, integrated treatment for co-occurring mental illness and substance abuse, and elimination of restraint and seclusion in inpatient facilities. SAMHSA reauthorization affords us an important opportunity to prod States toward investment in these innovative approaches.

Question 2. Ms. Halpern, you were able to access and receive services and supports. Why do so many other Americans have a difficult time receiving similar services?

Answer 2. Unfortunately, effective supports and services such as Assertive Community Treatment (ACT) are simply not available across the country. In order to effectively engage people with mental illness in treatment it often takes a willingness to meet people on their terms, where they live. This includes outreach and engagement on the streets, in homeless shelters, board and care homes, etc. Involvement of peer support and peer outreach is critical to making this kind of assertive engagement effective. We simply cannot allow community-based providers such as CMHCs and local public mental health service agencies to sit back and wait for consumers to voluntarily seek out treatment. Finally, we cannot lose sight of the fact that social withdrawal and social isolation are part of the very constellation of "negative" symptoms associated with an illness such as schizophrenia. These negative symptoms can have a profound effect on the ability of consumers to seek treatment on their own. This requires us to constantly be developing creative approaches to reach the most disabled and isolated people living with mental illness.

RESPONSE TO QUESTIONS OF SENATOR ENZI BY RODGER MCDANIEL

Question 1. In your oral and written testimony you encourage flexibility in the approach to funding effective treatment and prevention at the local level. One of the issues we are discussing in reauthorization of SAMHSA is the elimination of "silos" of service in exchange for more flexibility. Please explain in more detail what the optimum roles are for the Federal Government versus the local government in prevention and treatment from your experience in Wyoming.

Answer 1. In my view, the Federal Government can continue to play a very useful leadership role in steering the service system toward broad, comprehensive goals. Access to Recovery is an example of the use of funding to provide an incentive to involve the faith community as well as to expand the provider base beyond the usual set of State providers. The mental health system has, for example, used the President's New Freedom Commission ideas as the basis for transforming the mental health delivery system. The Federal Government also has an important role in defining not only client outcomes, but also performances measures for our systems of care. Accountability will be served if the State-Federal partnerships can implement standardized measures, are using common outcome measures such as the NOMS, to demonstrate the effectiveness of our services

The Federal Government can also play an important role by adequately funding research and the application of best practices. It is not helpful to cut the Addiction Technology Transfer Centers budget as proposed by the President. Nor is the proposed elimination of funding for Best Practices Coordination and Evidence Based practices. Any federally funded research needs to take into account the variation in needs from State to State given demographic and other defining differences. Finally the Federal Government needs to be consistent about its message. If Congress be-

lieves something is a priority, it needs to fund it. Establishing priorities without funding serves only to further overburden State and local systems that are generally straining under the pressure for services.

The role of the local community is a largely untapped resource in this effort. The opportunity for real progress toward meeting the challenges of substance abuse and mental health is at the community level. There are business and faith leaders, nonprofit organizations, members of the recovering community, and other citizens who want to be involved. The SPF SIG program has been a good example of community-State-Federal partnerships. Restrictive State and Federal grants have served to limit and dis-empower local leaders. Community leaders are closest to the problems and given flexible funding, they can identify the real needs of their neighborhoods and make the necessary choices. The environmental and cultural changes that are required to change negative trends are largely controlled by local communities. If they are not recognized for their key roles and given both the authority and the responsibility to make change, long-term solutions will remain elusive.

Question 2. It is clear that meth is fiercely addictive, and that individuals can be hooked from using just once. This makes it more difficult to target one specific population at risk for meth use. Therefore, how does an individual have access to treatment that fits that individual's need?

Answer 2. The balance between designating and serving priority populations vs. an open door policy to serve any individual in need of treatment is delicate. Ultimately decisions to treat should be based upon medical and clinical necessity which takes into account the unique needs of the client who desires or is in need of service. Every person should be screened, assessed and evaluated for services and if in need of treatment should be delivered in the lowest level of care possible.

In Wyoming, we are putting a great deal of emphasis on social marketing geared toward young people. Our hope is to raise awareness toward the severe impact of meth use on health, physical appearance, and all aspects of their development. Prevention is critical in meth because of the highly addictive nature of this drug.

Additionally, Wyoming has been working toward the regionalization of services. While not every county or community can afford to provide a full continuum of services, we believe it is important to recognize that service availability close to the client's home is essential to optimal recovery. Thus, we are gradually funding the continuum to each region. We are also expanding the availability of strategies such as tele-medicine.

Access to Recovery funds have been a tremendous help to us in the effort to provide meaningful early intervention for youth with meth or other drug or alcohol problems. Given the hideous nature of meth's addictive qualities, this early intervention with young people is a critical capability.

Finally, we are partnering with the departments of Corrections and Family Services to provide targeted, wrap-around services for mothers with young children. We intend to make use of para-professionals as family resource advocates. By recruiting, training, and certifying a workforce composed of recovering addicts, we can provide intensive in-home services to families. I see this as one effective answer to the problems of small communities recruiting a professional, therapeutic workforce.

Question 3. How have you worked to ensure that areas, especially rural areas have access to the most up-to-date information and resources to treat and prevent substance abuse?

Answer 3. The State of Wyoming contracts with the Center for Applied Science and Technology (CASAT; an organization independent of State government) to provide training, technical assistance, and certification of all substance abuse providers practicing in the State. A major portion of their work is conducting training events targeted at specific needs of individual centers, particularly those located in rural and frontier areas. Our State licensing law requires continuing education for license or certification retention, and these training events conducted by CASAT meet the required criteria for continued education.

The State recently invested in tele-medicine technology and workforce development, which will provide an additional opportunity for staff in remote areas to link with the educational presentations, training, specialized consultation and supervision that is essential in the implementation of evidence-based practices.

Question 4. Can you explain the 15/22 rule that you referred to in your written testimony?

Answer 4. Under the Adoption and Safe Families Act, if a child is in foster care for 15 of the last 22 months, the State is required to initiate legal proceedings to terminate parental rights. There is a broad, almost engulfing exception for what the law calls "compelling circumstances." Research shows that one of the strongest moti-

vating factors causing people to enter and remain in treatment is the loss of their children. If the system is able to make treatment available as quickly as possible after the children have been placed in foster care, more parents may be successfully reunited with their children.

The failure of judges to understand the brain science means that too often, addicted parents are simply court ordered into treatment with little or no meaningful supervision. In a family treatment court, the progress of the parent is closely monitored, unlike in most general family courts. If you study the brain scans, you will note that serious brain damage has occurred in the brain of the active addict. The neuro-biological damage to that portion of the brain where a person makes choices and exercises judgment precludes the addicted parent from following through without close supervision, drug testing, and a system of swift sanctions for violations. The addiction has also hijacked the brain's reward system. As a result, the person has come to rely on drugs to simply feel normal. There are research-based practices that re-institute the reward system, allowing the person to feel rewarded by engaging in positive, healthy behaviors. I have attached the research on the strategy known as "contingency management."

[Editor's Note: Due to the high cost of printing, previously published materials are not reprinted in the hearing record. The above referenced document may be found at http://www3.interscience.wiley.com.]

The primary point of my testimony was that the 15/22 rule can be effectively used along with best practices to significantly reduce the numbers of children removed from parental custody, and/or to greatly reduce the length of time children are in State custody. However, social workers, judges, and others need to understand the brain science so that our system contains programs with a greater likelihood of success.

RESPONSE TO QUESTIONS OF SENATOR ENZI BY TERRY ALLEBAUGH

Question 1. In your testimony you commented on the success your organization, New Hope, Inc., has seen through the Projects for Assistance in Transition from Homelessness (PATH) program; has your organization ever applied for the Grants to Benefit Homeless Individuals through SAMHSA?

Answer 1. Housing for New Hope has twice been part of a collaborative application for SAMSHA demonstration projects focusing on the chronic homeless in 2004 and 2005. Both applications were done with partner agencies in neighboring Wake and Orange Counties (along with Durham County, we are known as the Triangle), and were submitted by the Triangle United Way. Each Grant Opportunity had a very limited number of project awards, and though we received a relatively high score, we were not funded.

Question 2. Mr. Allebaugh, in your testimony, you mention that both men, Concrete and White Mike, declined offers that would connect them to services. Mike's story resulted in a positive outcome but it appears that Concrete has not been as successful thus far. How does your organization handle cases like Concrete and how does the Projects for Assistance in Transition from Homelessness (PATH) program help you in these endeavors?

Answer 2. It is through our operation of the PATH program that we made contact with Mike and Concrete. Through PATH we are able to outreach and connect some of the chronically homeless to services and housing. However, PATH staff cannot do any continued services once a person is referred to a clinical team. What SELHA would fund is clinical teams focusing on the homeless. This team could either intercede when Concrete was being released from the hospital, or work with the PATH team to engage, and then continue to render psychiatric services, thus providing a continuity of services, which is essential for this vulnerable population.

Question 3. One comment many States have expressed is that the flexibility of the grant programs within SAMSHA is one of the best characteristics of the program. Can you speak to the degree of flexibility within the PATH and reasons why PATH does not provide the flexibility New Hope identified in the Services for Ending Long-term Homelessness Act (SELHA) bill?

Answer 3. Re-stating from above, PATH is limited to providing outreach only, and we are prohibited from continuing services once we have referred a person to a clinical services provider. By requirement, PATH personnel are nonclinical. The problem arises that the existing pool of service providers have limitations in their capacity to serve the homeless. These include: inability to conduct outreach and engage the homeless and lack of knowledge and motivation to respond to the special characteristics and needs of the homeless. What we have learned from our experience is

that too many of the homeless we refer are not served by the current system and once again they fall through the cracks. With a clinical services team (funded through SELHA) working with the PATH outreach team, and with the availability of the housing units we have built and are building, we could outreach, house, and provide ongoing services, and thus bring stability into the lives of the chronically homeless, and end chronic homelessness in Durham.

RESPONSE TO QUESTIONS OF SENATOR BURR BY TERRY CLINE

Question 1. In an effort to make the most of limited Federal resources by leveraging funding partnerships, such as your partnership with the Department of Education under the "Safe Schools-Healthy Students" initiative, Senator Reed and I think SAMHSA should provide targeted funding for mental health and substance abuse services at "permanent supportive housing" facilities to help end the cycle of chronic homelessness.

The city of Portland recently reduced the number of chronically homeless by 70 percent when the city, the county, and the housing authority partnered to provide resources so agencies could open 480 new units of "permanent supportive housing."

I know SAMHSA has the authority to provide some funding to organizations providing services to homeless individuals, but how much of that currently supports this highly cost-effective model?

Answer 1. SAMHSA helps support services in permanent supportive housing primarily through two mechanisms. First, SAMHSA is a primary partner in the recently completed Collaborative Initiative to Help End Chronic Homelessness, the 3-year collaboration between HHS (SAMHSA and HRSA), HUD, and VA that addressed the mental health, substance abuse, primary health care, supportive housing, and other service needs of individuals experiencing chronic homelessness.

The very poignant example that you used regarding the success of the city of Portland in addressing chronic homelessness is germane to the Chronic Homelessness Initiative. Central City Concern, located in Portland, was one of the 11 sites under the Initiative. SAMHSA is gratified that one of our grantees helped contribute to helping to reduce chronic homelessness in their community.

In fiscal year 2007, SAMHSA issued a new funding announcement, titled the Services in Supportive Housing Program. This 5-year initiative will help end chronic homelessness by funding services for individuals experiencing chronic homelessness and families in coordination with existing permanent supportive housing programs and resources. The service grants are intended to fund programs that use services or practices that have been shown to be effective and that are appropriate for the target populations. Program and client outcome data will be collected and reported in accordance with the Government Performance and Results Act. Fiscal year 2007 funding of $3.5 million will allow SAMHSA to award eight grants.

While providing services to individuals living in permanent supportive housing has proven to be successful in addressing the needs of homeless individuals, it is not the only successful model for providing services to this population. SAMHSA also supports residential treatment programs that provide services to individuals who were homeless at intake. While supportive of services in permanent supportive housing, we want the flexibility to address the needs of homeless individuals in other settings that have proven to be successful as well. There are many ways to achieve our shared goal.

We also want to highlight that SAMHSA in its programs is focusing on recovery. As we look at recovery across our substance abuse and mental health portfolios, including the block grants, we are focusing on key elements of recovery including whether the individual has stable housing.

SAMHSA's total budget that addresses homelessness including the Projects of Assistance in Transition from Homelessness and discretionary grants focused on homelessness is $99,876,000 in fiscal year 2007.

Second, SAMHSA administers Grants for the Benefit of Homeless Individuals (GBHI) using its authority under Section 506 of the Public Health Service Act (PHSA).

The purpose of the program is to award grants, contracts and cooperative agreements to community-based public and private nonprofit entities for the purposes of providing mental health and substance abuse services to homeless individuals.

From a survey of grantees conducted in April 2007, we know that 20 percent of current GBHI grantees deliver supportive housing services. Therefore, we may estimate that $7,639,000 in 2006 funds for GBHI and $7,694,000 in 2007 funds will be used for supportive housing services. The remainder of GBHI funding supports services involving other types of housing.

In guidance given to grantees for the survey, supportive housing involves three essential elements:

(a) Permanent affordable housing, in any housing configuration (scattered, clustered, dedicated or mixed use single site [e.g., apartment building or SRO], units obtained from private landlords using tenant-based rent subsidies, etc.). [*Permanent housing* means no limit on length of stay and no requirement that tenants move out if their service needs change.]

(b) The housing is intended for, and for the most part actually occupied by, people who have been homeless or are at risk of homelessness and who have special needs including substance abuse problems or mental disorders, or other substantial barriers to housing stability.

(c) Supportive services attached that are designed to help people maintain the housing.

Thus, supportive housing does NOT include transitional (time-limited) housing or residential treatment, or projects that primarily help clients get housing subsidies *after* they complete a grant-funded treatment program. Supportive housing includes only the simultaneous provision of permanent housing and treatment services to homeless people.

[Whereupon, at 11:35 a.m., the hearing was adjourned.]

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