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# FEDERAL EFFORTS ON MENTAL HEALTH: WHY GREATER HHS LEADERSHIP IS NEEDED

## HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTEENTH CONGRESS

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# FEDERAL EFFORTS ON MENTAL HEALTH: WHY GREATER HHS LEADERSHIP IS NEEDED

**WEDNESDAY, FEBRUARY 11, 2015**

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON ENERGY AND COMMERCE,
*Washington, DC.*

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

Members present: Representatives Murphy, McKinley, Burgess, Blackburn, Griffith, Bucshon, Flores, Brooks, Mullin, Hudson, Collins, Cramer, DeGette, Schakowsky, Tonko, Yarmuth, Clarke, Kennedy, and Pallone (ex officio).

Staff present: Gary Andres, Staff Director; Sean Bonyun, Communications Director; Karen Christian, General Counsel; Noelle Clemente, Press Secretary; Brad Grantz, Policy Coordinator, Oversight and Investigations; Brittany Havens, Legislative Clerk; Charles Ingebretson, Chief Counsel, Oversight and Investigations; Peter Kielty, Deputy General Counsel; Alan Slobodin, Deputy Chief Counsel, Oversight; Sam Spector, Counsel, Oversight; Peter Bodner, Democratic Counsel; Hannah Green, Democratic Policy Analyst; Tiffany Guarascio, Democratic Deputy Staff Director and Chief Health Advisor; Elizabeth Letter, Democratic Professional Staff Member; and Nick Richter, Democratic Staff Assistant.

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

Mr. MURPHY. Good morning. I now convene this morning's hearing entitled, "Federal Efforts on Mental Health: Why Greater HHS Leadership is Needed."

In December 2013, Laura Pogliano of Maryland sent to me a poem she wrote about what it is like to raise a child with schizophrenia, as opposed to other life-threatening conditions. Here is an excerpt: "Your child's illness is afforded the cooperation of caregivers and parents to attend to it. My child's illness is left to the right to refuse care laws, leaving him to get as sick as he can possibly be, and choose suicide, death, starvation, and continued illness with severe brain damage. Your child is never arrested or jailed because he is sick. My child is almost always arrested at some point. Your child can have any bed in any hospital in the country across the board. My child can only have a psychiatric bed. And there is an estimated deficit of 100,000 beds in this country,

and the wait for one can take 6 months or longer in some places. Your child can tell people if he is sick. My child cannot, or he won't get a job or a date or an apartment. Your child can get a fun trip sponsored by an organization that assists sick children. My child can't go on any trips usually, and neither can his family."

Despite her struggles getting Zac into care, Laura considered herself lucky, telling USA Today in November that, even though her son's mental illness has driven her to bankruptcy, sidetracked her career, and left her clinically depressed, she called herself lucky, though Zac was in and out of a hospital 13 times in 6 years. She said, even though he has fantasies that he is rich, hallucinations that he is being followed, and delusions that his mother is a robot, even though he has slept with a butcher knife under his pillow, Laura considered herself lucky that Zac wasn't in jail or homeless.

Last month, Zac was found dead in his apartment. He was 23 years old.

Laura had dreams for her son, Zac, just like every parent does. For countless parents, those dreams are tragically cut short. She searched for help and faced barriers to care. Federal laws, HIPAA laws, state laws. We have criminalized mental illness so you can't get help unless you are homicidal, suicidal, or you are well enough to understand you have problems and ask for help.

This has been a growing problem since states closed down their old asylums, as they should have, but what did the Federal Government do here to take care of this problem, to meet the needs of millions of Americans with serious mental illness and their families?

Today, we will hear how our mental health system is an abject failure for those families. Its failure is not a Democrat or Republican issue; it knows no party label, and to be honest, this spans multiple administrations, but the cost is enormous for the 10 million Americans with serious mental illness. Those with schizophrenia die 25 years earlier than the rest of the population. Forty thousand people in this country died last year from suicide, while another million attempted it in the last year. And that is a trend that is getting worse. Rates of homelessness, incarceration, unemployment, substance abuse, violence, victimization, and suicide among those with serious mental illness continue to soar. These are the very human, very tragic, and very deadly results of a very, very bad report card.

Today, thanks to a diligent year-long review of Federal efforts related to severe mental illness conducted at the bipartisan request of this committee, the Government Accountability Office has produced unassailable evidence that our mental health system is dysfunctional, disjointed, and a disaster.

No Federal agency has had a more central role in the disaster than the Department of Health and Human Services. HHS is charged with leading the Federal Government's public health efforts related to mental health, and the Substance Abuse and Mental Health Services Administration, otherwise known as SAMHSA, is required to promote coordination of programs related to mental illness throughout the Federal Government. At the onset of our investigation 2 years ago, we found it troubling that no one in the

Federal Government kept track of all the Federal programs serving individuals with severe mental illness. My colleague and I, Representative Diana DeGette, asked GAO to take on this task. Following a detailed survey of eight Federal departments, including the Department of Defense, Veterans Affairs, and HHS, the GAO identified at least 112 separate Federal programs supporting individuals with severe mental illness. But most damning in this GAO report were these two principal findings. One, interagency coordination for programs supporting individuals with serious mental illness, a key function of SAMHSA, is lacking. And number two, to see whether programs specifically targeted at individuals with serious mental illness are working, agencies evaluated fewer than ⅓ of them.

Now, you can't manage what you don't measure. For families who want and need treatment, HHS has given families bureaucracy, burdens and barriers instead.

We spend a lot of money in this country on mental illness, and the term evidence is thrown around like candy to prevent people from asking where is the real proof that this works. GAO offered two recommendations to correct these failings. HHS rejected them both. In each instance, HHS dismissed GAO's concerns rather than presenting evidence to dispute GAO's conclusions or volunteering improvements, or having the humility to say maybe we ought to do something about this.

When you have a mental health system that is as broken as the one we face today, with a report card so tragic, you would think that the Federal agency charged with coordinating a myriad of activities supporting individuals with severe mental illness would be open to recommendations from an experienced, nonpartisan authority, steeped in the practices of good government. HHS, in rejecting both of GAO's recommendations, and failing to identify any aspect of either recommendation worth working with or leaning from, is essentially saying there is no room for improvement, and that the agency is doing everything right at present. This is unbelievable.

The hubris shown by HHS is downright insulting and callous to the millions of families and individuals suffering under this broken system. This is a clear example of unaccountable government; one that refuses to recognize its failings even when it is presented with constructive recommendations for improvement.

We want to help in this committee, this Congress wants to help, but we can't help you if you are not even willing to admit there is a problem. We are not talking simply about wasted dollars or lost program efficiencies. We are talking about lives ruined, about dreams that are shattered, we are talking about preventable tragedies and lives lost.

I have spoken before about individuals with schizophrenia and bipolar disorders who aren't just in denial, but have the very real medical pathology that they cannot recognize they have an illness. It is called anosognosia, and it is a symptom found in stroke victims, Alzheimer patients, and persons with schizophrenia. HHS and SAMHSA are similarly in denial. You are so out of touch with understanding their own failures that it causes greater pain to millions of American families. Meanwhile, the lives of individuals with severe mental illness and their families remain in the balance.

This morning, we will hear from the author of the GAO report, as well as representatives from HHS. These include Dr. Linda Kohn, Director of Health Care at GAO; Dr. Richard Frank, Assistant Secretary for Planning and Evaluation at HHS; and Pamela Hyde, Esquire, the Administrator of SAMHSA. I thank them all for joining us this morning, and I would like to give the ranking member an opportunity to deliver remarks of her own.

[The prepared statement of Mr. Murphy follows:]

## PREPARED STATEMENT OF HON. TIM MURPHY

In December 2013, Laura Pogliano of Maryland sent to me a poem she wrote about the what it's like to raise a child with schizophrenia as opposed to other life-threatening conditions. Here's an excerpt:

Your child's illness is afforded the cooperation of caregivers and parents to attend to it.

My child's illness is left to the Right to Refuse Care Laws, leaving him to get as sick as he can possibly be, and choose suicide, death, starvation, continued illness with severe brain damage.

Your child is never arrested or jailed because he's sick.

My child is almost always arrested at some point.

Your child can have any bed in any hospital in the country, across the board.

My child can ONLY have a psychiatric bed, and there's an estimated deficit of 100,000 beds in this country, and the wait for one can take 6 months or longer in some places.

Your child can tell people he's sick. My child cannot, or he won't get a job, or a date, or an apartment.

Your child can get a fun trip sponsored by an organization that assists sick children.

My child can't go on any trips, usually, and neither can his family...

Despite her struggles getting Zac into care, Laura considered herself lucky, telling USA Today in November that "even though her son's mental illness has driven her to bankruptcy, sidetracked her career and left her clinically depressed."

She called herself "lucky" even though Zac was in and out of the hospital 13 times in 6 years.

"Even though he has fantasies (he's rich), hallucinations (he's being followed) and delusions (Mom is a robot). Even though he's slept with a butcher knife under his pillow."

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This has been a growing problem since states closed down their old asylums—as they should have. But what did the federal government do here?

Today, we'll hear how our mental health system is an abject failure for those families. Its failure is not a Republican or Democrat issue. It knows no party label and spans multiple Administrations.

The cost is enormous for the ten million Americans with serious mental illness.

Those with schizophrenia die 25 years earlier than the rest of the population.

40,000 die from suicide while another million will have attempted it in the last year alone, a trend that's getting worse

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At the onset of our investigation two years ago, we found it troubling that no one in the federal government kept track of all of the federal programs serving individuals with severe mental illness. My colleague Diana DeGette and I asked GAO to take on this task. Following a survey of eight federal agencies, including the Departments of Defense, Veterans Affairs, and HHS, GAO identified at least 112 separate federal programs supporting individuals with severe mental illness.

Most damning in the GAO report were these two principle findings:

(1) interagency coordination for programs supporting individuals with serious mental illness, a key function of SAMHSA, is lacking

(2) to see whether programs specifically targeting individuals with serious mental illness are working, agencies evaluated fewer than one-third of them.

You can't manage what you don't measure, which is why HHS has given families and individuals who want and need treatment bureaucracy, burdens, and barriers instead.

We spend a lot of money and the term "evidence" is thrown around like candy—to prevent people from asking where the true proof that it really works.

GAO offered two recommendations to correct these failings; HHS rejected them both, in each instance dismissing GAO's concerns rather than presenting evidence to dispute GAO's conclusions orvolunteering improvements.

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This morning, we will hear from the author of the GAO report, as well as representatives of HHS. These include:

- Linda T. Kohn, PhD, Director, Health Care at GAO;
- Richard G. Frank, PhD. Assistant Secretary for Planning and Evaluation at HHS; and
- Pamela S. Hyde, Esquire, Administrator of SAMHSA.

I thank them all for joining us this morning.

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

Ms. DEGETTE. Thank you, Mr. Chairman.

This is an issue that is important to both of us, and so I am really glad that you have convened this hearing as part of our continuing oversight of the Federal Government's mental health programs.

This hearing, as the chairman mentioned, follows a report by the GAO released last week, which raises questions about the more than 100 programs that generally support individuals with serious

mental illness, and 30 programs that specifically target those individuals.

In particular, the GAO report raises questions about the coordination and evaluation of mental health programs, and offers recommendations to help us improve the mental health system.

I look forward to hearing our witnesses' testimony today because they are very familiar with the report and the issues that it raises, and I know that we will all be able to see further insights and context for our understanding of the Federal role in mental health care.

The report provides us with an importance chance to assess current Federal efforts to address mental health, and to see where there is room for improvement in our system. And I know we can all agree there is ample room for improvement. I want to hear about how we can ensure that Federal programs actually assist people who need them, and I also think we need to talk about how to assess the efficacy and cost of those programs.

While it is important to talk about providing services and support to those with serious mental illnesses, I think we also need to have a broader conversation about mental health in this country. According to the National Institute of Mental Health, we have nearly 44 million individuals, almost 19 percent of all U.S. adults, living with mental illness every year. And, Mr. Chairman, as we have discussed, sometimes if we can help folks in the early stages of mental illness, then that helps us begin to prevent the disintegration into very, very serious mental illness and worse.

So we have spent a lot of time on this subcommittee looking at mental health issues. We have learned about the need to appropriately target mental health funding, and the need to adequately fund mental health research. We have learned about the importance of health insurance that provides coverage for those with mental illnesses. I know, Mr. Chairman, that you want to pass mental health legislation that will make a real difference. I do too. I hope there are ways that we can work through these issues and concerns on a bipartisan basis, with the focus group that we have put together over the last year. I think we should work together to put the lessons learned in these Oversight hearings into practice.

I want to thank all of the witnesses for being here today. It is important to hear from all of you. I know we can agree there is always room for improvement, and we look forward to hearing from you about how we can do that.

With that, I will yield the balance of my time to Representative Kennedy.

Mr. KENNEDY. I want to thank the ranking member, and I thank the chairman for calling this important hearing. I thank the witnesses for their testimony today, and for your work on an extraordinarily important issue.

This report outlines alarming lapses in coordination at the Federal level. It raises questions about how Federal funds are being spent, and points a finger at our Nation's patchwork mental health system for failing to meet the needs of millions of Americans.

Back home, I see communities on the frontlines of a growing crisis, looking for the Federal Government for support. From sub-

stance abuse to at-risk youth, our failure to delivery dependable, affordable, and accessible mental health care is costing lives back at home.

So instead of throwing in the towel, we should see this report as a rallying cry. We must do better, devote more resources to mental illness, invest in our efforts at improving coordination, evaluation, and delivery of care. But for that to work, we need to know the scope of the problem and the range of our response. We must have the commitment of our Federal partners to take on a growing problem. Lasting mental health reforms are long overdue, and I look forward to working with all of you. And I want to thank again the chairman and ranking member for calling this important hearing.

I yield back.

Mr. MURPHY. Yields back. Thank you.

I now recognize the vice chair of the full committee, Mrs. Blackburn of Tennessee, for 5 minutes.

**OPENING STATEMENT OF HON. MARSHA BLACKBURN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TENNESSEE**

Mrs. BLACKBURN. Thank you, Mr. Chairman. And I want to welcome our witnesses, and highlight a couple of things that have already been said that I think are important to all of us on the panel.

As the chairman mentioned, 10 million adults in the U.S. had a serious mental illness during 2013. That should not be lost on us. And we also were very concerned about coordination of care, and we are going to have some questions about that. I have discussed this with some of the mental health professionals in my district who are involved in this coordination of care. And Ms. DeGette's comments are so on point with so much of what we are going to look at, the money that is spent. Your budget is a hefty budget for substance abuse and mental illness, but the lack of coordination of care, the lack of the resources meeting the needs at the local and state agencies, how this feeds through, this is something that does cause us concern. We are pleased to hear from the GAO today, and we want to look at where the recommendations the GAO has, how they have fallen on deaf ears at HHS and SAMHSA, and we are concerned about the delivery of parity, if you will, in mental illness and addressing those needs, and we are concerned with what appears to be a great deal of indifference when it comes to just spending money but not getting results.

So I will yield back my time, Mr. Chairman, or yield to whomever would like to have the time. And we look forward to hearing from our witnesses.

Mr. MURPHY. Thank you.

Does anybody on this side wish to make any comments? If not, then we will proceed. Thank you.

Mr. Pallone. I am sorry, Mr. Pallone is here now. Mr. Pallone is recognized for 5 minutes.

**OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY**

Mr. PALLONE. Thank you, Mr. Chairman. Thank you for convening the hearing today. And I am glad we are taking this opportunity to examine how the Federal Government supports individuals with serious mental illness, but also looking into how we can strengthen our mental health system for the future. We all agree that there are ways we can do better.

The GAO report we are talking about today calls for improved coordination and evaluation of Federal programs that help those with serious mental illness. And these are valuable goals, but I want to make sure we don't discount the work HHS, SAMHSA, and other Federal agencies are already doing in these areas.

The GAO report identified 112 programs across the Federal Government that support those with serious mental illness. Now, within that group, there are 30 programs that specifically focus on individuals with serious mental illness. GAO, however, did not review the merits or quality of these programs, so we should hear from HHS and SAMHSA about the work they are doing, how these programs help individuals with a variety of needs, and how these agencies plan to build upon these programs moving forward.

It is also important to emphasize that HHS, SAMHSA, and their partners across the Federal Government do coordinate on mental health programming. The GAO report notes that, and I quote, "Staff from 90 percent of the programs targeted serious mental illness reported coordinating with their counterparts and other programs."

HHS coordinates with a number of departments and agencies, including the Department of Defense, the Department of Veterans Affairs, the Department of Education, to carry out critical programs for individuals with serious mental illness. SAMHSA also co-chairs the HHS Behavioral Health Coordinating Council, which includes a Subcommittee on Serious Mental Illness.

The GAO report also noted that SAMHSA had completed, or was in the process of completing, nine program evaluations in the past several years, and I look forward to hearing from SAMHSA about the results of these evaluations, and how they have improved program efficiency and effectiveness, as well as how SAMHSA utilizes other monitoring and evaluation tools. Notably, the GAO report did not review the programs that provide reimbursement of insured services for individuals with serious mental illness, including Medicare and Medicaid. These programs are a huge part of the work HHS does to support early diagnosis and treatment of mental illness.

And lastly, Mr. Chairman, I want to highlight the role of the Affordable Care Act in guaranteeing coverage of mental health services. Continuing implementation of the ACA will go a long way in ensuring that people with serious mental illness have access to the treatments they need. In fact, we should support programs that focus on prevention and early diagnosis of mental illness. We can more effectively support individuals with serious mental illness by treating them early in the course of their illnesses, and altering the trajectory of their condition.

So again, I want to thank our witnesses. And I would like to yield my remaining time to the gentleman from New York, Mr. Tonko.

Mr. TONKO. I thank the ranking member of our Energy and Commerce Committee for yielding. And I thank you, Mr. Chair, and, Ranking Member DeGette, for holding this hearing on such a critically important topic.

As I travel around my congressional district in the capital region of New York, I hear stories daily from individuals and families as they struggle with the ravages of mental illness. Their pain is indeed real, and we must commit this Congress to doing everything within its power to ease their burdens.

In that vein, I welcome today's hearing, and the underlying GAO report that we are here to discuss as it advances the conversation on some basic good governance questions on how the Federal Government should approach programs aimed at helping individuals with serious mental illness. And while I concur with the report's conclusion that high-level coordination can be essential to identifying gaps in services and evaluating overall efforts, it is important to keep in mind that coordination is not an end unto itself. Where additional interagency coordination, whether at the programmatic or department level, can be an effective use of the Federal Government's time and money, and more importantly, is beneficial to individuals with serious mental illness, we should welcome it. Where it does not meet that test, we should not be adding additional layers of bureaucracy that divert time and resources from the people that need it the most.

As such, I look forward to hearing from our witnesses today on where coordination efforts can be built upon so that we can have an improved outcome for those living with mental illness.

And I thank you and yield back the balance of my time.

Mr. MURPHY. The gentleman yields back.

So at this point, we will proceed with testimony of our witnesses. I would now like to introduce the panel.

First, we have Dr. Linda Kohn, who is Director with the Health Care Team at the U.S. Government Accountability Office, where she works on issues related to public health, health information technology, and medical research programs. Welcome. Dr. Richard Frank is the Assistant Secretary for Planning and Evaluation at the U.S. Department of Health and Human Services. In this role, he advises the Secretary on development of health and disability, human services data, and science policy, and provides advice and analysis on economic policy. Welcome here. And the Honorable Pamela Hyde is accompanying Dr. Frank. Ms. Hyde is the Administrator of the Substance Abuse and Mental Health Services Administration, otherwise known as SAMHSA. Ms. Hyde has more than 35 years of experience in management and consulting for public health care and human service agencies.

I will now swear in our witnesses.

You are all aware that the committee is holding an investigative hearing, and when doing so, has the practice of taking testimony under oath. Do any of you have any objections to testifying under oath? Seeing that no one has an objection, the chair then advises you that under the rules of the House and the rules of the com-

mittee, you are entitled to be advised by counsel. Do any of you desire to be advised by counsel during testimony today? And all the witnesses decline. In that case, would you all please rise and raise your right hand, and I will swear you in?

[Witnesses sworn.]

Mr. MURPHY. You are now under oath and subject to the penalties set forth in Title XVIII, section 1001 of the United States Code.

You may now each give a 5-minute summary of your written statement. Please make sure the microphone is turned on and close to your face.

Dr. Kohn, you may begin. Make sure the microphone is on and pulled close.

Ms. KOHN. Is it on? Got it. OK.

Mr. MURPHY. Thank you.

**STATEMENTS OF LINDA T. KOHN, PH.D., DIRECTOR, HEALTH CARE, U.S. GOVERNMENT ACCOUNTABILITY OFFICE; RICHARD G. FRANK, PH.D., ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; ACCOMPANIED BY PAMELA S. HYDE, J.D., ADMINISTRATOR, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION**

**STATEMENT OF LINDA T. KOHN, PH.D.**

Ms. KOHN. Thank you, Chairman Murphy, Ranking Member DeGette, and members of the subcommittee. I am pleased to be here today to talk about GAO's recent report on Federal programs related to serious mental illness. Our report calls for leadership from HHS to coordinate Federal efforts in addressing the needs of this very vulnerable population.

Our report has three major findings, and I will touch briefly on each. First, we found 112 programs across eight different agencies that serve the needs of people with serious mental illness, and 30 of these programs target or specifically focus on people with serious mental illness. We believe it is unlikely that all the programs were identified because agencies had difficulty identifying them, not because they weren't willing to, that was not an issue, but the agencies didn't always have information on the extent to which a program was serving the seriously mentally ill, although they knew that their programs were serving that population; for example, a program related to homelessness.

The list we think is also incomplete because agencies varied in how they decided which programs to include in their responses to us. So, for example, DoD identified all of their suicide prevention programs in their list of programs for the seriously mentally ill, but SAMHSA initially did not because they saw the program as serving a broader population. Subsequently, SAMHSA added these programs to the list.

There was another example, HUD and VA jointly administer a housing program for disabled veterans. VA put it on the list of programs, HUD didn't put it on the list of programs. So there are a number of examples like that, and it is that kind of variation that

can limit comparability among similar programs. So this list is a starting point, not an ending point.

Our second objective related to coordination, and we found that while the staff involved in implementing these programs reported taking steps to coordinate activities with staff in other agencies, we were unable to identify any formal mechanism to support interagency coordination at a higher level. And such coordination, GAO believes, could help comprehensively identify the programs, resources, and potential gaps or duplication in Federal efforts that support the seriously mentally ill.

In the past, HHS has led the Federal Executive Steering Committee for Mental Health with members from across the Federal Government, but that group hasn't met since 2009. HHS told us that another group, the Behavioral Health Coordinating Council, performed some of the activities previously done by the Steering Committee, but that council is limited to HHS and doesn't have members from across the Federal Government.

We identified examples of other interagency committees, but they tended to be broader in scope, such as the focus on homelessness or focused on a specific population such as veterans. It is important to emphasize, and has been noted, that the staff that carry out the programs reported to us that they were working with colleagues in different agencies, and trying to coordinate their efforts. That is a very positive thing in place, however, staff at the program level are not necessarily in the right position to identify possible gaps, potential duplication, whether Federal resources are being spent wisely. Getting that kind of an overarching perspective requires some higher level, interagency coordination, and we called on HHS to establish a mechanism for that. HHS did not agree because they said that coordination is already occurring at the programmatic level, but for the reasons I noted, we continue to believe that action is necessary.

Our third recommendation related to evaluation, and we found that as of September 2014, across the 30 programs that specifically target the seriously mentally ill, fewer than ½ had evaluations that were done in the last 5 years or were underway. Of the completed evaluations, SAMHSA had evaluated the greatest proportion of their programs, seven of the 13 programs they listed, and had two evaluations underway. And there were a couple of other evaluations that were done at DoD.

We recognize program evaluations can be costly and very time-consuming, and that the agencies need to prioritize those efforts. Our report also notes that the agencies reported to us that they do other program monitoring activities. They look at data performance measures, they stay on top of the literature to understand how to improve programs and identify improvements, and again, that is a very important component, but we don't believe that performance monitoring takes the place of formal program evaluations that can examine the overall effectiveness of a program.

We called on four agencies that sponsor programs that target the seriously mentally ill; specifically, DoD, Justice, HHS, and VA, to document which of their programs should be evaluated and how often. DoD, Justice, and VA agreed with our recommendation; HHS

did not agree, and suggested our report overemphasized the role of evaluations, but again, we continue to believe that action is needed.

That concludes my prepared remarks. Thank you very much.

[The prepared statement of Ms. Kohn follows:]

United States Government Accountability Office

Testimony

Before the Subcommittee on Oversight and Investigations, Committee on Energy and Commerce, House of Representatives

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# MENTAL HEALTH

# HHS Leadership Needed to Coordinate Federal Efforts Related to Serious Mental Illness

Statement of Linda T. Kohn
Director, Health Care

GAO-15-375T

Chairman Murphy, Ranking Member DeGette, and Members of the Subcommittee:

I am pleased to be here today to discuss our recent report on federal programs supporting individuals with serious mental illness.[1] As you know, mental illness is widespread in the United States. According to figures from the Substance Abuse and Mental Health Services Administration (SAMHSA)—an agency within the Department of Health and Human Services (HHS)—an estimated 43.8 million—or 18.5 percent—of adults in the United States suffered from a mental illness in 2013. Among those, about 10 million—or 4.2 percent—of adults in the United States suffered from a serious mental illness.[2]

Today, the federal government provides a range of programs to support the needs of individuals with serious mental illness, such as funding block grants to community mental health organizations and providing supportive housing programs for individuals with mental illness. The responsibility for the administration and evaluation of these programs falls upon multiple agencies, including the Department of Defense (DOD), Department of Education (Education), HHS, Department of Housing and Urban Development (HUD), Department of Justice (DOJ), Department of Labor (DOL), Department of Veterans Affairs (VA), and Social Security Administration (SSA). Programs supporting individuals with serious mental illness may or may not be specifically targeting that population. For example, a program providing housing for homeless veterans may provide support to individuals with serious mental illness because these individuals make up a portion of the population of homeless veterans, but

[1]GAO, *Mental Health: HHS Leadership Needed to Coordinate Federal Efforts Related to Serious Mental Illness*, GAO-15-113 (Washington, D.C.: Dec. 18, 2014).

[2]Data are from the 2013 National Survey on Drug Use and Health, a national survey administered by SAMHSA.

the program is targeting homeless veterans rather than individuals with serious mental illness.[3]

Our prior work has noted the importance of coordinating and evaluating programs. This is particularly important in the case of federal efforts to support serious mental illness, given the size of the population affected and the complexity of treatment. We have reported on the importance of coordination between federal agencies on issues of national significance as a way to avoid fragmentation.[4] Many of the meaningful results that the federal government seeks to achieve require the coordinated efforts of more than one federal agency and often more than one sector and level of government. In addition, for many years, we have reported that more frequent evaluations of performance and results were needed for multiple federal programs and activities.[5]

In this context, my statement today discusses the findings from our recent December 2014 report on federal programs supporting individuals with serious mental illness. Accordingly, this statement addresses (1) the

[3]For the purposes of this statement and our December 2014 report (GAO-15-113), we define individuals with serious mental illness as adults who currently or at any time in the past year have had a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet certain diagnostic criteria, as specified within the Diagnostic and Statistical Manual of Mental Disorders (DSM), that resulted in serious functional impairment, substantially interfering with or limiting one or more major life activities. Individuals with serious mental illness may also include those with a specific diagnosis; for example, individuals diagnosed with schizophrenia, schizoaffective disorder, bipolar disorder, or major depression. In addition, we defined individuals with serious emotional disturbance as children and adolescents from birth up to age 18 who currently or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM that resulted in functional impairment, which substantially interferes with or limits the child's role or functioning in family, school, or community activities. Throughout this statement, when we refer to programs generally supporting or specifically targeting individuals with serious mental illness, we are referring to programs supporting or targeting individuals with either serious mental illness or serious emotional disturbance.

[4]We define coordination as any joint effort that is intended to produce more public value than could be produced when organizations act alone. Fragmentation refers to those circumstances in which more than one federal agency is involved in the same broad area of national need and opportunities exist to improve service delivery.

[5]GAO, *Government Efficiency and Effectiveness: Opportunities to Reduce Fragmentation, Overlap, and Duplication through Enhanced Performance Management and Oversight*, GAO-13-590T (Washington, D.C.: May 22, 2013).

federal programs that support individuals with serious mental illness; (2) the extent to which federal agencies coordinate programs for individuals with serious mental illness; and (3) the extent to which federal agencies evaluate or monitor programs for individuals with serious mental illness. In addition, I will highlight key actions that we recommended in our report that federal agencies can take to better understand the full breadth of federal programs supporting those with serious mental illness, the scope of federal resources expended on those programs, and the effectiveness of the programs.

To conduct this work, we developed a web-based questionnaire with questions about program goals, target populations, services offered, performance information and evaluations, coordination, and funding in fiscal year 2013. We administered the questionnaire to eight agencies frequently cited as having relevant programs supporting individuals with serious mental illness, as based on a review of existing documentation and interviews with agency officials and advocacy groups. We supplemented the questionnaire responses with follow-up interviews and questions to each of the agencies to obtain any additional information. Our December 2014 report includes a detailed explanation of the methods used to conduct our work. We conducted the work on which this statement is based in accordance with generally accepted government auditing standards.

## Eight Agencies Reported over 100 Programs That Can Support Individuals with Serious Mental Illness, but It Is Unlikely All Programs Were Identified

Agencies identified 112 federal programs that generally supported individuals with serious mental illness in fiscal year 2013. The majority of these programs addressed broad issues, such as individuals suffering from homelessness, which can include individuals with serious mental illness. The programs were spread across eight federal agencies: DOD, DOJ, DOL, Education, HHS, HUD, SSA, and VA. These 112 programs conducted activities that can generally support individuals with serious mental illness. For example, HUD's Continuum of Care program provided funding to nonprofit providers and state and local governments to quickly find housing for homeless individuals and families, among other services. The number and purpose of the programs identified by the agencies through our questionnaire varied widely. DOD reported the largest number, a total of 34 programs, and HHS identified 33. Although some programs may serve more than one purpose, overall, many of the programs focused on the provision of support services and a few programs focused on research or surveillance.

A subset of the 112 programs—30 programs, or 27 percent—were identified by the agencies as specifically targeting individuals with serious mental illness. These targeted programs were administered by five agencies—DOD, DOJ, HHS, SSA, and VA—and the primary purpose for them varied. Half of the targeted programs provided support services such as case management. The other half of the targeted programs served a mix of purposes, including prevention, research, technical assistance, and treatment.

It is unlikely that agencies identified all programs for individuals with serious mental illness. Agencies had difficulty identifying all of their programs supporting individuals with serious mental illness because they did not always track whether or not such individuals were among those served by the program. For example, the Disability Employment Initiative administered by DOL is intended to serve all people with disabilities, including individuals with serious mental illness, but it was unclear how many individuals with serious mental illness were served by this program. Agencies also varied in which programs they identified because they had different definitions of what such a program might be. For example, DOD officials identified all of their suicide prevention programs as those that support individuals with serious mental illness, but SAMHSA officials did not initially include any of their suicide prevention programs, explaining that these programs were not limited only to individuals with serious mental illness and served a broader population. Subsequently, after further discussion with us, SAMHSA included the agency's suicide prevention programs among those that can support individuals with serious mental illness.

The inability of agencies to identify a comprehensive list or inventory of programs for individuals with serious mental illness is problematic. The Government Performance and Results Modernization Act of 2010 requires the Office of Management and Budget to compile a comprehensive list of all federal programs identified by agencies, and to include the purposes of each program, how it contributes to the agency's mission, and recent funding information.[6] This information could help assist executive branch and congressional efforts to identify and address fragmentation, overlap, and duplication.

[6]Pub. L. No. 11-352, § 7, 124 Stat. 3866, 3876 (Jan. 4, 2011).

## Interagency Coordination of Programs Supporting People with Serious Mental Illness Is Lacking

Interagency coordination for programs supporting individuals with serious mental illness is lacking. HHS is charged with leading the federal government's public health efforts related to mental health, and SAMHSA is required to promote coordination of programs relating to mental illness throughout the federal government. In the past, HHS led the Federal Executive Steering Committee for Mental Health, with members from across the federal government. However, the steering committee has not met since 2009. HHS officials told us that the Behavioral Health Coordinating Council (BHCC) performs some functions previously carried out by the steering committee. The BHCC, however, is limited to HHS and is not an interagency committee. Other interagency committees are broad in scope and did not target individuals with serious mental illness. For example, HHS officials reported that the U.S. Interagency Council on Homelessness—formed to coordinate the federal response to homelessness—has worked to improve access to behavioral health services in an effort to address chronic and veteran homelessness. Accordingly, the work of this committee might affect individuals with serious mental illness, but the committee did not specifically focus on the unique needs of this population.

Although coordination specific to serious mental illness was lacking among interagency committees, staff for the majority of the programs targeting serious mental illness reported taking steps to coordinate with staff in other agencies. For example, program staff from SAMHSA's Criminal and Juvenile Justice programs told us that they met quarterly with program staff for DOJ's Bureau of Justice Assistance Justice and Mental Health Collaboration program. While coordination at the program level is important, it does not take the place of, or achieve the level of, leadership that we have previously found to be key to successful coordination. We have also found that coordination at the leadership level is essential to identifying whether there are gaps in services and if agencies have the necessary information to assess the reach and effectiveness of their programs. In our December 2014 report, we recommended that HHS establish a mechanism to facilitate intra- and interagency coordination, including actions that would assist with identifying the programs, resources, and potential gaps in federal efforts to support individuals with serious mental illness. HHS did not agree with our recommendation. HHS stated that because funding for SAMHSA is largely allocated to specific programs by Congress, improving coordination should include coordination at the Congressional level. HHS also said that coordination was already occurring at the program level. Based on the results of our review, we continue to believe that action is needed by HHS to address our recommendation. Coordination at the

program level is important but cannot take the place of coordination at higher levels that would provide the perspective needed to assess the reach and effectiveness of all the federal government's programs targeting individuals with serious mental illness.

## Agencies Have Evaluated Less than One-Third of the 30 Programs Targeted for People with Serious Mental Illness

Agencies completed few evaluations of the programs specifically targeting individuals with serious mental illness. As of September 2014, of the 30 programs specifically targeting individuals with serious mental illness, 9 programs had a completed program evaluation—7 by SAMHSA and 2 by DOD. In addition, 4 programs had an evaluation underway, and 17 programs had no evaluation completed and none planned. In some instances, agency officials provided explanations for the lack of completed program evaluations, citing—for example—the cost of conducting evaluations, especially for small programs.

Agency officials said they engaged in other efforts—such as drawing on evidence in published literature—to ensure their programs were effective. Agency officials also cited the use of ongoing monitoring and assessment activities for several of their programs targeting people with serious mental illness. Our prior work has shown the significance of both performance monitoring activities and program evaluations and noted the importance of formal program evaluations to inform program managers about the overall design and operation of the program. Although our past work has found that some program evaluations can be expensive, the relatively few evaluations completed among programs targeted for individuals with mental illness is a concern because without meaningful and timely evaluations, agencies may lose opportunities to identify improvements in federal government efficiency and effectiveness, and because comprehensive evaluations can be key to coordinating and streamlining federal programs.[7] In our December 2014 report, we recommended that DOD, DOJ, HHS, and VA—which oversee programs targeting individuals with serious mental illness—document which of their programs targeted for individuals with serious mental illness should be evaluated and how often such evaluations should be completed. DOD, DOJ, and VA agreed with our recommendation. Although HHS acknowledged that performance measurement is important, it did not

[7]GAO, *Grants Management: Enhancing Performance Accountability Provisions Could Lead to Better Results*, GAO-06-1046 (Washington, D.C.: Sept. 29, 2006).

agree with our recommendation and suggested that our report places undue importance on program evaluations. We disagree with HHS's characterization and believe that actions to address our recommendations are needed by all relevant agencies.

In conclusion, individuals with serious mental illness can face significant challenges getting the services they need. The public health, social, and economic impact of serious mental illness, coupled with the constrained fiscal environment of recent years, highlights the need to ensure that federal programs efficiently and effectively use their resources to support the complex needs of individuals with serious mental illness.

Chairman Murphy, Ranking Member DeGette, and Members of the Subcommittee, this concludes my prepared statement. I would be pleased to answer any questions that you may have at this time.

If you or your staff members have any questions concerning this statement, please contact me at (202) 512-7114 or kohnl@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Other individuals who made key contributions to this statement include Tom Conahan, Assistant Director; Carolyn Fitzgerald; Cathy Hamann; Jacquelyn Hamilton; Mollie Hertel; Hannah Marston Minter; Vikki Porter; Michael Rose; and Joanna Wu.

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Mr. MURPHY. Thank you, Dr. Kohn.

Dr. Frank, you are recognized for 5 minutes.

**STATEMENT OF RICHARD G. FRANK, PH.D.**

Mr. FRANK. Good morning, Chairman Murphy, Ranking Member DeGette, and members of the subcommittee. My name is Richard Frank, and I am the Assistant Secretary for Planning and Evaluation. I am pleased to be here to discuss coordination of care for people with serious mental illness. I have dedicated much of my career to studying mental health care and mental health policies, so it is gratifying to participate in a serious conversation on this issue.

The occasion that brings us here is the release of GAO's report on efforts to coordinate care for people with serious mental illness. Past GAO reports on serious mental illness have had profound effects on this Nation's mental health policy. I think of the 1977 report, Returning the Mentally Disabled to the Community, Government Needs to Do More, as having set the standard. The GAO showed how government could best support people with serious mental illness by improving the care they receive from community providers.

Today's report falls short of that earlier effort. It doesn't adequately make the connection between government activities and meeting the complex needs of people with serious mental illness.

In the time I have with you, I aim to make some of those connections; one, by offering a more complete view of HHS programs that serve people with serious mental illnesses; two, by describing the investments that we are making to coordinate services for this population; and three, to explain our evaluation efforts.

Serious mental illnesses are not a diagnosis. Serious mental illness is how we talk about a collection of conditions and impairments that disrupt peoples' lives, much as the chairman mentioned. Therefore, serious mental illness does not fall easily into quantified categories of programs, peoples, and dollars.

Let me begin first by outlining the role of the Federal Government in serving people with serious mental illnesses, and putting that into context.

Medicare and Medicaid Supplemental Security Income and Social Security Disability Insurance are the largest sources of public support for people with serious mental illnesses. With regard to HHS programs that pay for and deliver mental health services, Medicare and Medicaid account for 40 percent of national spending on mental health care, and an even larger share of care for people with serious mental illnesses. All other Federal programs, including SAMHSA's programs, account for 5 percent of spending. The remaining 55 percent is made up of spending by private insurance, state and local government expenditures, and out-of-pocket payments by households. By focusing on the 5 percent, the GAO report overlooks much of HHS activities regarding caregiving and support for people with serious mental illnesses. HHS leadership recognizes the need to coordinate services for this population. Coordination can be thought of in a number of ways. It can occur at the level of formal coordination across large Federal agencies, at the program level, at the provider level, or at the level of the individual beneficiaries where providers, programs, and people interact.

People do not live their lives according to program boundaries, and we have learned not to run our programs as if they do. As a result, we have been making substantial investments in new organizations and institutions that coordinate public services at the level of the individual beneficiary. A few important examples include SAMHSA's Primary Behavioral Health Care Integration, or PBHCI, Program, Medicaid Health Homes, and the Integrated Care demonstration for beneficiaries that are dually eligible for Medicare and Medicaid.

The GAO report also raised the issue of evaluation to develop evidence to guide program design and funding decisions. We have, and are conducting a variety of important and rigorous evaluations of programs that coordinate care for people with serious mental illnesses. They include evaluations of programs run by SAMHSA, CMS, Social Security, HUD, and by states using Federal program funds. The results of evaluations have shaped legislation, program design and regulations.

I will highlight two to give you a flavor of our efforts. First, ASPE has worked with SAMHSA to evaluate primary behavioral health care integration programs, showing how coordination across providers affects health and mental health of people with serious mental illnesses. Second, we will be evaluating early intervention programs for serious mental illnesses, in conjunction with the Social Security Administration and in relation to SAMHSA's block grant set aside. In addition, SAMHSA, ASPE, and CMS are jointly developing new performance and quality measures that are essential to conducting evaluations and monitoring progress.

This Administration has shown a deep commitment to addressing mental health care, and support for serious mental illnesses, specifically. It is that commitment that was an important factor in my returning to work here at HHS. I am proud of the record to date, but I know we can do more. More needs to be done, and I hope to join you in doing just that.

Thank you.

Mr. MURPHY. Thank you.

Ms. Hyde, you are recognized for 5 minutes.

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

Ms. HYDE. Good morning, Chairman Murphy, Ranking Member DeGette, and members of the subcommittee. My name is Pamela Hyde and I am the Administrator of the Substance Abuse and Mental Health Services Administration.

In 2014, over ¾ of SAMHSA's mental health funding was targeted toward improving the lives of persons with serious mental illness, or SMI. Individuals with SMI in their families, like those I have met, served, and advocated for over 4 decades, are the reason we are, at SAMHSA, working so hard to coordinate critical Federal programs to maximize the impact on the ground for those who need it the most. For example, SAMHSA and other HHS agencies work with the U.S. Interagency Council on Homelessness, the Departments of Veterans Affairs and Housing and Urban Development, to prioritize the needs of veterans and individuals experiencing chronic homelessness; many of whom have serious mental illnesses. Because of these joint efforts, 25,000 fewer people experienced chronic

homelessness in 2014 than in 2013, and the number of homeless veterans has declined 33 percent.

I also represent Secretary Burwell as co-chair of the President's Interagency Task Force on Military and Veterans Mental Health. Through this effort, SAMHSA is working with the Department of Defense, VA, and the White House to address the mental health needs of military families. SAMHSA also leads the Interdepartmental Federal Working Group on suicide prevention, and helps fund and support the Federal and private sector collaboration that developed, and is beginning to implement the Surgeon General's national strategy on suicide prevention.

In 2014, the National Suicide Prevention Lifeline, funded by SAMHSA, and coordinated with the VA, served over 1.3 million Americans.

SAMHSA's Children's Mental Health Initiative coordinates mental health, education, juvenile justice, and human services structures that serve young people with serious emotional disturbances. Evaluations of this program have demonstrated impressive results in improving functioning, reducing arrests, suicidal thoughts, and days spent in inpatient care, and increasing family satisfaction with services.

Along with the Assistant Secretary for Health, I co-chair the Secretary's Behavioral Health Coordinating Council, which includes a new subcommittee focused on the needs of persons with SMI, and other subcommittees that address issues affecting SMI individuals and their families across multiple programs.

SAMHSA also coordinates Federal efforts informally. For example, SAMHSA worked with the Departments of Labor and Education to develop and disseminate a toolkit about supported employment for persons with SMI. In 2014, SAMHSA implemented a new grant program to test how to help states take this evidence-based practice to scale.

In 2014, SAMHSA also implemented new congressional language requiring that at least 5 percent of each state's mental health block grant funds be used to provide treatment and services for individuals with first-episode serious mental illness. SAMHSA is coordinating with the National Institute of Mental Health to provide guidance and technical assistance to help states implement evidence-based interventions to prevent the disability often associated with early onset SMI.

Also new in 2014 is the President's Now is The Time plan, which grew out of the tragedy in Newtown, Connecticut, and received broad bipartisan support by Congress. This series of programs allows us to increase the behavioral health workforce, train and support school personnel, and assist youth and young adults, especially those with serious emotional disturbances, to be identified and receive the treatment they need for emerging mental health and substance use problems as they transition to adulthood. These new programs necessitate robust interdepartmental coordination with other HHS agencies. The Departments of Education and Justice, and state education and behavioral health entities, as well as students, families, and community responders.

And in collaboration with the Departments of Treasury and Labor, SAMHSA and other HHS agencies have coordinated efforts

to help individuals with significant behavioral health needs enroll in newly available affordable care coverage, and to help plans and consumers know about their obligations and rights under National parity legislation.

Even though much has been accomplished, we recognize the need to do more. The President's 2016 budget proposes a new SAMHSA Crisis Services Program to bring together multiple state, Federal, and community funding streams, and service deliver infrastructures so that emergency rooms, inpatient residential and treatment facilities, and jail cells will not be the only options for SMI individuals in crisis and their families.

SAMHSA works every day to coordinate and collaborate within the Federal Government and across the country to assure evidence-based treatment is available and delivered so individuals with SMI and their families can live satisfying and productive lives. We appreciate Congress' continuing partnership in these efforts.

Thank you.

[The prepared statement of Mr. Frank and Ms. Hyde follows:]

Testimony

of

Richard G. Frank, PhD.

Assistant Secretary for Planning and Evaluation

and

Pamela S. Hyde, J.D.

Administrator, Substance Abuse and Mental Health Services Administration

U.S. Department of Health and Human Services

before the

House Committee on Energy and Commerce

Subcommittee on Oversight and Investigations

Hearing on GAO Report 15-113

"Mental Health: HHS Leadership Needed to Coordinate Federal Efforts Related to Serious Mental Illness"

February 11, 2015

Chairman Murphy, Ranking Member DeGette and members of the Subcommittee, thank you for this opportunity to discuss how the Department of Health and Human Services (HHS) is supporting the needs of people with serious mental illnesses. We share your interest in improving care for this population, and others with mental illness, and look forward to continuing to work with you on this important issue.

As a Nation, we have come a long way in understanding the causes of serious mental illnesses and how to treat and support the people who experience them. Indeed, a snapshot of the mental health system in the 1950s would have shown a system that spent around 80 percent of its resources on warehousing people in institutions.[1] Modern day behavioral health care for those with the most serious illnesses offers new opportunities for rehabilitation and integration into society that would not have been conceivable half a century ago. For example, during the 1950s and 1960s about 27 percent of people with serious mental illnesses were institutionalized and today it is only about seven percent (including those that are incarcerated).[2] Moreover, for people with serious mental illnesses, rates of treatment have grown dramatically. For example between 1990 and 2003 the percentage of people with serious mental illness receiving care increased by about 67 percent.[3] Nonetheless, serious mental illnesses can be devastating for individuals and families and much work is needed to reduce the burden of these disorders. We continue to work to address homelessness associated with those with serious mental illness, people with mental illness housed in the criminal justice system, and other painful consequences of people going without treatment and services.

**Overview**

HHS delivers treatment and supports to people with serious mental illnesses through its major health and social service programs – programs that serve this population along with Americans impacted by a wide range of diseases and conditions – as well as through specialized programs that provide targeted services to people with serious mental illness. HHS also conducts research on the biological processes that lead to serious mental illnesses. Although most of the funding for services for people with serious mental illnesses comes through our Federal insurance programs, especially Medicaid, the Substance Abuse and Mental Health

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[1] Frank RG, Glied SA. Better But Not Well: Mental Health Policy in the United States Since 1950. Baltimore: The Johns Hopkins University Press, 2006.
[2] Frank and Glied see note 1.
[3] Kessler RC et al, US Prevalence and Treatment of Mental Disorders 1990-2003; New England J Medicine 352 (24) 2515-2523, 2005.

Services Administration's (SAMHSA's) programs are critical in supporting the coordination of services for people with serious mental illnesses and improving the quality and accessibility of these services and supports. We agree with the U.S. Government Accountability Office (GAO) that coordination is essential for improving care and outcomes for people with serious mental illnesses, who have such complex health care and support needs. Thus, we work at many levels – inter-Departmental, inter-agency, and most importantly at the individual patient-level – to ensure the efficient and effective coordination of the programs and resources aimed at meeting those needs. Finally, we want to assure you of our commitment to program evaluation and accountability through performance measurement and that the Department and its agency components are working together to continuously improve our programs.

**How We Care for People with Serious Mental Illnesses**

Medicare, Medicaid, Supplemental Security Income, and Social Security Disability Insurance (SSDI) represent the largest sources of support for people with serious mental illnesses. With respect to mental health services, Medicaid and Medicare account for 40 percent of total spending on mental health care and a substantially larger portion of spending for people with serious mental disorders.[4] In fact, Medicaid is the single largest source of financing for mental health care in the United States including for people with serious mental illnesses (27 percent in 2009).[5] Federal funding for mental health services from all other sources accounts for five percent of total spending on mental health. The GAO report is focused on programs that make up this five percent of overall spending. While these programs, including the programs funded by SAMHSA, are important for development and implementation of evidence-based treatments, improving coordination of available resources and supports, broadening specialty care capacity and infrastructure, and collecting impact and general surveillance data, they make up a relatively small portion of HHS's overall spending on serious mental illnesses.

We expect millions of additional low-income adults with mental illness to gain coverage through the Medicaid expansion in the Affordable Care Act.[6] Recently,

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[4] Substance Abuse and Mental Health Services Administration. National Expenditures for Mental Health Services and Substance Abuse Treatment, 1986–2009. HHS Publication No. SMA-13-4740. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013. Available on-line at http://store.samhsa.gov/product/National-Expenditures-for-Mental-Health-Services-and-Substance-Abuse-Treatment-1986-2009/SMA13-4740.

[5] *Id.*

[6] Garfield RL, Zuvekas SH, Lave JR, et al. The Impact of National Health Care Reform on Adults with Severe Mental Disorders. American Journal of Psychiatry. 2011; 168(5): 486-494.

experts have estimated that Medicaid coverage expansion will also increase coverage for people with serious mental illnesses.[7] There is encouraging evidence from a pre-Affordable-Care-Act Oregon Medicaid demonstration that randomly assigned eligible individuals to a modest size Medicaid expansion. The evaluation of that effort showed, among other improved outcomes, increased care for depression resulting in lower levels of symptoms of depression in the newly covered population.[8] Improving access to mental health treatment through broad-based health and human service programs is a critical step toward improving outcomes for people with serious mental illness, who often are disengaged and disenfranchised as a result of their illness.[9]

Also not addressed in the GAO report is the increasingly important role that private health insurance plays in serving people with mental disorders,[10] particularly after enactment of the Mental Health Parity and Addiction Equity Act (MHPAEA) and the coverage expansions and protections for people with preexisting conditions in the Affordable Care Act. The Affordable Care Act also significantly extends the reach of the MHPAEA's requirements. The Affordable Care Act requires all non-grandfathered small group and individual market plans to comply with Federal parity requirements. Qualified Health Plans offered through the Health Insurance Marketplace in every state must include coverage for mental and/or substance use disorders as one of the 10 categories of Essential Health Benefits, and that coverage must comply with the Federal parity requirements set forth in the MHPAEA. Emerging evidence, such as significant increases in health care coverage among young adults,[11] and dramatic upticks in utilization of inpatient care for mental health and substance use conditions in that population,[12] suggests that these reforms are improving access to mental health care. Similarly, recent findings from SAMHSA's National Survey on Drug Use and Health (NSDUH) show this expanded coverage has resulted in a significant rise in the percentage of

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[7] Mark TL, Weir LM, Malone K, et al. National Estimates of Behavioral Health Conditions and their Treatment Among Adults Newly Insured under the Affordable Care Act. *Psychiatric Services in Advance*, accessed on-line February 3, 2015.

[8] Baicker K, Taubman SL, Allen HL, et al. The Oregon Experiment – Effects of Medicaid on Clinical Outcomes. *N Engl J Med.* 2013 May 2; 368(18): 1713-1722.

[9] *See, e.g.*, American Mental Health Counselors Association, Broken Promises; More Despair; How the Lack of State Participation in the Medicaid Expansion Will Punish Americans with Mental Illness. February 2014. Available online at http://www.amhca.org/assets/content/AMHCA_DashedHopes_Report_2_21_14_final.pdf.

[10] Mark TL, Weir LM, Malone K, et al. National Estimates of Behavioral Health Conditions and their Treatment Among Adults Newly Insured under the Affordable Care Act. Psychiatric Services in Advance, accessed on-line February 3, 2015.

[11] Martinez ME, Cohen RA. Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January-September, 2012. March 2013. Available online at http://www.cdc.gov/nchs/data/nhis/earlyrelease/Insur201303.pdf.

[12] Health Care Cost Institute, Issue Brief No. 8: Selected Health Care Trends for Young Adults (ages 19025): 2007-2012. September 2014. Available online at www.healthcostinstitute.org.

young adults receiving mental health services in the past year – from 10.9 percent in 2010 to 11.9 percent in 2012. The study also shows that people in this age group who were insured were nearly twice as likely to receive mental health treatment as those without health insurance (13.5 percent versus 6.7 percent).

**Targeted Programs Are Vital**

The inclusion of mental health care into broader healthcare programs does not diminish the importance of targeted programs that direct specialized resources and expertise towards addressing the needs of people with serious mental illnesses and help us learn more about what works for them. Our success depends on making investments in specialized infrastructure and continuing our efforts to develop specialized treatment and support interventions. SAMHSA is central to this effort. The vast majority of SAMHSA's mental health spending targets individuals with serious mental illnesses. In FY 2014, over three-quarters of funding appropriated to SAMHSA for mental health services supported adults with or at risk for serious mental illnesses and/or children with serious emotional disturbances. This includes major programs such as the Community Mental Health Services Block Grant; the Children's Mental Health Initiative; and the Primary and Behavioral Health Care Integration (PBHCI) program. In addition, SAMHSA's homeless services programs, the largest of which are required in authorizing legislation to serve only those with serious mental illnesses, are prioritizing Veterans and people that are chronically homeless because such a high proportion of them have serious substance use disorders and/or serious mental issues.

The National Institute of Mental Health (NIMH) is also focused on improving care for individuals with serious mental illnesses through significant research investments to strengthen the evidence base for program and service delivery. One important project at NIMH is the Recovery After an Initial Schizophrenia Episode (RAISE) study. This study is a randomized controlled trial of specialized, team-based care for first episode psychosis in over 400 individuals at 34 community treatment centers across the United States. This project seeks to fundamentally change the trajectory and prognosis of schizophrenia through coordinated and aggressive treatment in the earliest stages of illness. Improving access to comprehensive specialized care is critically important to lessening the impact of serious mental illness. However, we know that, currently, it often takes over a year after a person first experiences psychosis – before they receive treatment for that condition.[13] As discussed in more detail below SAMHSA has been closely coordinating with NIMH to incorporate evidence developed from the

[13] Addington J, Heinssen RK, Robinson DG, et al. Duration of Untreated Psychosis in Community Treatment Settings in the United States. Psychiatric Services in Advance. Accessed on-line February 3, 2015.

RAISE project into SAMHSA's technical assistance efforts. Moving beyond first episode psychosis to earlier stages of psychosis risk, NIMH also developed the Early Psychosis Prediction and Prevention program to support high-quality research aimed at preventing psychosis onset among persons at clinical high-risk. NIMH funded five grants in FY 2014 that will inform a step-wise approach to clinical high-risk care that can be implemented rapidly in the U.S. healthcare system.

**Coordination**

There has been a long-standing interest among government officials and other stakeholders in improving coordination of the array of services and supports needed by people with serious mental illness.[14] Coordination can and should occur on multiple levels within the government and through a variety of means. Coordination can be achieved through formal interagency mechanisms, through program-level collaboration, or around a particular consumer's needs. We believe that coordination is needed at all levels, and a focus on consumer-centered care is critically important if outcomes are to improve for this very vulnerable population.

*Consumer-Centered Care Coordination*

People do not lead their lives according to program boundaries, and we have learned that we cannot run programs as if they do. That is why we devote substantial resources to models, programs, and demonstrations that focus on coordinating services for individuals across programs and agency boundaries. SAMHSA leads a number of our most important initiatives to coordinate services at the level of the individual beneficiary.

SAMHSA's Primary and Behavioral Health Care Integration (PBHCI) program is a prime example of how HHS' programs coordinate care for individual consumers through multi-agency cooperation. To date, over 125 community behavioral health centers across the United States have received PBHCI grants to provide integrated behavioral health and primary care services for adults with serious mental illnesses. Four main activities are required of PBHCI grantees: screening and referral for health care, systematically tracking consumers' physical health status and care needs, care management, and prevention and wellness services. SAMHSA has worked with the Office of the Assistant Secretary for Planning and Evaluation (ASPE) at HHS on an evaluation of this program that found that the program increased access to primary care services, as well as improved health

[14] Frank RG, Glied SA. *Better But Not Well: Mental Health Policy in the United States Since 1950.* Baltimore: The Johns Hopkins University Press, 2006.

outcomes for individuals with serious mental illness with co-occurring diabetes, high cholesterol, and hypertension. As part of PBHCI, SAMHSA and the Health Resources and Services Administration (HRSA) co-fund the Center for Integrated Health Solutions (CIHS). CIHS promotes the development of integrated primary and behavioral health services to better address the needs of individuals with mental health and substance use conditions – especially those with serious mental illness, whether seen in behavioral-health or primary-care provider settings.

We also know that people with serious mental illnesses and their families often find themselves facing crisis situations in which the only available care is overworked emergency rooms often ill-equipped to address the needs of such individuals. That is why the President's FY 2016 Budget includes a new demonstration program in SAMHSA designed to help states and communities test the best way to structure, fund and deliver services to prevent, de-escalate and follow-up after behavioral health-related crises to assure the individual, family, community and delivery systems are adequately supported in such circumstances. The goal of this program is to test how best to reduce the need for inpatient care by providing earlier and more effective crisis services that bring multiple local, state and Federal funding sources together to adequately fund coordination of care across multiple settings and multiple community systems.

We also have a number of important care coordination initiatives focused on individuals with serious mental illnesses in HHS's broad-based programs. The health home option in Medicaid is focused on promoting care coordination for high-need individuals with an emphasis on people with serious mental illness. The health home benefit provides an enhanced Federal Medicaid match for care coordination, transitional care, linkages to community and social support services, and health information technology for individuals with multiple chronic conditions or a serious mental illness. Eligible providers include community mental health centers that are lynchpins of the public mental health care system. A number of states are targeting their health home benefits to individuals with serious mental illnesses, including New York, North Carolina, South Dakota, Vermont, Ohio and Missouri. In implementing the health home benefit, the Centers for Medicare & Medicaid Services (CMS) has collaborated closely with other agencies in the Department including SAMHSA and ASPE. For example, SAMHSA has helped review states' plans for health homes and provided consultation to states that focus this coordination benefit on individuals with mental illness or substance abuse. ASPE has been working with CMS to carry-out a five year evaluation of the health home option that will include detailed information on how states have implemented the benefit, as well as impacts on quality of care, inpatient and

emergency room utilization, and costs for the individuals receiving this enhanced coordination benefit.

Our coordination efforts are especially evident with regard to the Department's work to improve coordination of care for those eligible for both Medicare and Medicaid, the "dual eligibles." We know that a high percentage of dual-eligible beneficiaries have serious mental health conditions.[15] These beneficiaries are among the sickest and poorest people covered by either Medicare or Medicaid. Integrated care demonstrations to coordinate service delivery and financing of both Medicare and Medicaid through a Federal-state collaboration have been implemented in twelve states.[16] The Massachusetts demonstration, for example, focuses on nonelderly dually eligible beneficiaries, a subpopulation of dually eligible beneficiaries with a high prevalence of serious mental illnesses and other behavioral health conditions. The Massachusetts demonstration incorporates an array of benefits designed to support persons with serious mental illness, including assertive community treatment, community crisis stabilization, psychiatric day treatment, and emergency services.

There are a number of new initiatives within Medicare focused on improving care coordination and promoting Accountable Care Organizations (ACOs), including the Medicare Shared Savings Program and the Pioneer ACO Model. Providers in these ACOs can receive shared savings for improving quality, care coordination, and reducing costs or pay shared losses in some cases for failing to meet certain benchmarks on quality and cost. These ACOs are accountable for care to Medicare beneficiaries assigned to the ACO, including individuals with serious mental illness.

SAMHSA also continues to prioritize and implement major programs designed to meet the needs of people with serious mental illness who experience criminal justice involvement, homelessness, and poverty (*e.g.*, Behavioral Health Treatment Court Collaborative, Cooperative Agreements to Benefit Homeless Individuals, and Projects for Assistance in Transition from Homelessness). For example, to improve consumer-centered coordination on the ground, SAMHSA administers the Cooperative Agreements to Benefit Homeless Individuals Program. The major goal of this program is to ensure, through state and local planning and service delivery, that Veterans who experience homelessness, as well as other homeless

[15] Medicare Payment Advisory Commission and Medicaid and CHIP Payment and Access Commission. Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid. January 2015. Available on-line at http://www.macpac.gov/publications; Frank RG, Epstein AM. Factors Associated with High Levels of Spending for Younger Dually Eligible Beneficiaries with Mental Disorders. *Health Affairs*. June 2014; 33(6): 1006-1013.
[16] CA, CO, IL, MA, MI, MN, NY, OH, SC, TX, VA, and WA.

individuals (which is a population with high levels of serious mental illness), receive access to sustainable permanent housing, treatment, recovery supports, Medicaid and other benefits. Other SAMHSA programs that focus on care coordination for individuals with serious mental illness include the Behavioral Health Treatment Court Collaborative and Projects for Assistance in Transition from Homelessness.

Recently, SAMHSA has been working closely with CMS and ASPE to improve the quality and coordination of care for people with serious mental illness through implementation of a new demonstration program for Certified Community Behavioral Health Clinics established by the Protecting Access to Medicare Act. This program will provide enhanced Medicaid reimbursement for care coordination and comprehensive services at treatment centers that typically serve mostly individuals with serious mental illness. Just last week, SAMHSA released for public comment the draft criteria for community behavioral health clinics to be certified by states under the Section 223 demonstration program.

Participating centers will be required to meet staffing requirements, a comprehensive scope of services, standards for availability and accessibility of services, including prompt evaluation and crisis management services, and extensive requirements for enhanced care coordination. In addition, treatment centers will be required to report on quality measures that will include measures of care coordination. These data will inform an evaluation of this program that will be conducted by ASPE in close collaboration with SAMHSA and CMS.

*Intra-Departmental Coordination*

Beyond our focus on making sure services are coordinated for people with serious mental illness at the point of service, we are also engaged in efforts to coordinate across agencies within HHS. While the GAO report does not focus on coordination at the program level, we believe this is vital. Collaboration and coordination among programs can be very effective at ensuring Federal efforts are not inconsistent or overlapping. This collaboration at the program level is critical for ensuring that our best understanding of how to improve care for individuals with serious mental illness is being shared and implemented.

Established in 2010 by HHS, the Behavioral Health Coordinating Council's (BHCC) chief goals are to share information and ensure that all behavioral health issues are being handled collaboratively and without duplication of effort across the department. The BHCC's Serious Mental Illness Subcommittee is co-chaired by SAMHSA's Administrator and NIMH's Director and is helping to facilitate cross-agency collaborations. Topics that are a current

focus of this subcommittee include: surveillance; early identification and intervention; engagement/outreach with consumers and their families such as psycho-education, peer and family support, shared decision-making, privacy and access to information issues; crisis response; provider capacity and training; and research priorities and opportunities for further collaboration across the Federal Government.

In addition to the cross-agency collaborations mentioned previously regarding PBHCI, Health Homes, and various other programs, SAMHSA has been closely coordinating with NIMH to incorporate information from the RAISE project into technical assistance for the states to use in implementing a new set-aside of Mental Health Block Grant funds for early intervention services. Recognizing the importance of engaging individuals with serious mental illnesses as early as possible in specialized services, the Congress recently required states to use five percent of the FY 2014 and FY 2015 Mental Health Block Grant funds they receive from SAMHSA to develop and support early intervention programs.[17] Multiple HHS agencies – including ASPE, SAMHSA, and NIMH – are working together to study how states are implementing the set-aside while also planning on a fuller evaluation of the impact of the set-aside in years to come.

Additionally, since 1989, SAMHSA has provided leadership by jointly funding, with the National Institute on Disability and Rehabilitation Research (NIDRR) of the Department of Education,[18] Research and Rehabilitation Training Centers that have conducted research on service delivery, employment, community living, health, and transition to adulthood for individuals with serious mental illness or serious emotional disturbance across their lifespan.

*Inter-Departmental Coordination*

At the interdepartmental level, there are also a number of coordinating bodies that focus on the needs of individuals with serious mental illness. Our approach to coordinating housing and services for the chronically homeless is an example of on the ground program coordination that is an outgrowth of Federal agencies reaching across program boundaries. The U.S. Interagency Council on Homelessness, co-chaired by Secretary Burwell along with Secretary Perez of the Department of Labor (DOL), has been invaluable in bringing together the resources and programs necessary to address the needs of individuals with chronic homelessness – the vast majority of whom have serious mental illness.

[17] Approximately $24.2 million in funds each year.

[18] With the signing of the Workforce Innovation and Opportunity Act of 2014, NIDRR became the National Institute on Disability, Independent Living, and Rehabilitation Research, and was moved to the Administration for Community Living in HHS.

We also engage in direct collaborative work with other Departments including collaborations with the Department of Housing and Urban Development and the Social Security Administration (SSA) on efforts to coordinate care and support of people with serious mental illnesses. For instance, HHS has been engaged in a workgroup led by the Office of Management and Budget (OMB) that includes representatives from DOL, the Department of Education (ED), and SSA to develop a demonstration project for intervening earlier and diverting individuals from reliance on SSDI. We are now working across these departments to plan this demonstration that will primarily focus on people in the early stages of a serious mental illness. The intervention is in its early stages of development but will combine evidence based clinical care with well tested work support approaches.

In addition, SAMHSA leads both the Federal Working Group on Suicide Prevention and the Federal Partners Committee on Women and Trauma. The Administrator of SAMHSA also represents the HHS Secretary as co-chair of the Interagency Task Force on Military and Veterans Mental Health that includes HHS, ED, the Departments of Defense (DoD) and Veterans Affairs (VA), OMB, and the White House to address these and other issues affecting service members, Veterans and their families. Further efforts that exemplify SAMHSA's interagency coordination include the National Suicide Prevention Lifeline which SAMHSA co-leads with the VA, and the SAMHSA-funded National Action for Suicide Prevention, co-led by the Under Secretary of Defense for Personnel and Readiness, at DoD.

For people with serious mental illness, employment contributes to stability and independence. Unfortunately, many people with serious mental illness are unemployed. In FY 2014, SAMHSA initiated a new program, Transforming Lives through Supported Employment, to promote the employment of people with serious mental illness, and this initiative includes collaboration with ED, DOL, and states, among others.

We know that part of the answer to keeping individuals and their families supported and gainfully participating in regular community life is coordination across systems of care. Across many Departments, we have made significant investments in coordination because we know that it is one of the critical engines driving our programs to success.

We believe that our current methods of program coordination are robust and effective; however, we continue to look for ways to improve that coordination. As such, we take seriously GAO's recommendation to develop a more formal

mechanism to further facilitate interagency coordination and thus enhance current coordination efforts.

**Meaningful Program Evaluation is Key to Improving Services**

GAO also challenges us to be rigorous about evaluation and performance measurement so we can monitor outcomes and progress. HHS is committed to evaluation of our programs, use of evaluation results in program design, and an on-going process to improve the reach and quality of our evaluation efforts. ASPE is engaged in reviews of our approaches to evaluation across the Department. Our programs that serve people with serious mental illnesses are the subject of rigorous and ongoing evaluation to measure their impacts.

SAMHSA's Center for Behavioral Health Statistics and Quality includes a Quality, Evaluation, and Performance Branch which conducts a variety of evaluations of SAMHSA programs. A cross-agency SAMHSA Evaluation Team helps determine which programs will be monitored through performance data and which programs will be evaluated more intensely through SAMHSA or external evaluation efforts. This branch also collaborates with ASPE, other HHS officials, and academic experts in planning, conducting, and reporting evaluation results to health professionals and the public. But SAMHSA's portfolio on evaluation work, like its investments in mental health system and service supports, is but one component of a multi-faceted evaluation approach.

Evaluations offer opportunities to coordinate across agencies regarding programs targeting individuals with serious mental illness. For example, ASPE has worked closely with SAMHSA for a number of years on an evaluation of the PBHCI program. In addition, ASPE is coordinating with CMS on an evaluation of the Medicaid health home benefit. Most recently, ASPE, SAMHSA, and CMS have been working together to develop the evaluation for the Certified Community Behavioral Health Clinic Demonstration. ASPE is also working with NIMH and SAMHSA to examine implementation of the set-aside of Mental Health Block Grant funds for early intervention services for individuals in the early stages of serious mental illness, including psychotic disorders.

ASPE, SAMHSA, and CMS are working together to look for opportunities to enhance the evaluation of HHS programs and also improve the availability of performance measures for monitoring the impact of our programs on people with serious mental illness

Key to the success of evaluation is having strong performance measures. SAMHSA, working with ASPE, has funded the development and testing of a

number of health care quality measures specific to people with serious mental illness. This work focuses on testing whether evidence-based care is being provided to persons with these conditions. Eleven of these measures have been submitted to and favorably reviewed by the National Quality Forum for measure endorsement as health plan quality measures. Such measures are part of SAMHSA's National Behavioral Health Quality Framework. NIMH and ASPE have also been co-leading an effort to develop a quality measure for evidence-based treatment for post-traumatic stress disorder. In addition, ASPE has been working with CMS to develop measures to include in the new reporting requirements in Medicare for inpatient psychiatric facilities – including a measure of whether individuals with serious mental illnesses coming out of these facilities are being adequately connected with services in the community.

In addition, NIMH, SAMHSA, VA, ASPE, and a number of mental health stakeholder groups have joined to fund the Institute of Medicine to chart a course forward on improving the quality of psychosocial interventions.

**Lessons Learned**

While we look for opportunities to continuously update and improve our programs, we have learned a lot about what works and what needs to be emphasized in supporting people with serious mental illness.

First and foremost, services must be coordinated on the ground so that they meet the often complex needs of people with serious mental illnesses. This is especially the case when the vast majority of services and supports for people with these conditions are delivered through general health and income support programs.

Second, coordination at high levels of Government is desirable and can help meet the needs of people at the point of service.

Third, coordination at the level of agencies that directly interact with people receiving publicly or privately funded services is vitally important.

Coordination at each of these levels is needed to best serve the needs of individuals with serious mental illness – and we are committed to achieving that goal.

Much progress has been made over the past half century and there have been many champions along the way. We look forward to partnering with the Congress to continue to improve care for individuals with the most serious mental illnesses.

Mr. MURPHY. Thank you. I thank the witnesses for their testimony.

I am now going to recognize myself for 5 minutes. Just for the record, I just want to make it clear, Dr. Kohn, you have never treated a patient with mental illness, correct?

Ms. KOHN. No, I have not.

Mr. MURPHY. Dr. Frank, you never have? You have never treated anybody with mental illness, right? That is not your field, correct? And, Ms. Hyde, you have never treated anybody in the service for mental illness, correct?

Ms. HYDE. Right.

Mr. MURPHY. I just want to be on the record. That way—yes.

So, Dr. Kohn, despite HHS's disagreement with your recommendations, does GAO stand by its report and its recommendations?

Ms. KOHN. We do. We continue to believe that action is needed in both areas. We think there can be greater coordination to provide that overarching perspective. It is not that we didn't acknowledge a number of——

Mr. MURPHY. OK, I just need to have that yes or no. I——

Ms. KOHN. Yes.

Mr. MURPHY. Thank you. Dr. Frank, in this 2006 book that you wrote, Better But Not Well, you wrote that individuals with a mental illness have flexible entitlements to an array of largely uncoordinated programs and resources. The resources flow from a dizzying range of Federal, state, and private organizations. Do you still believe that?

Mr. FRANK. I believe that continues to be the case.

Mr. MURPHY. I want to post these two posters. One is a list of all the Federal programs on the right there, and then I have put together, based upon the GAO report, the organizational flowchart of the programs on the left, using your term dizzying array.

So you still believe that? Yes?

Mr. FRANK. I believe that there is a complex set of needs provided by a complex set of organizations for people with serious mental illness.

Mr. MURPHY. The law states that SAMHSA must promote the coordination of service programs conducted by other departments, agencies and organizations, and individuals that are or may be related to the problems of individuals suffering from mental illness. So yes or no, do you believe SAMHSA is responsible for the interagency coordination of mental health programs?

Mr. FRANK. I am focused with——

Mr. MURPHY. Well, it is a yes or no. I have just read you what is the regulations of law. Is that true or not?

Mr. FRANK. Well, SAMHSA has some responsibilities. What I want to do is point out that it is very important in our view how services actually get coordinated on the ground for people, and part of that is——

Mr. MURPHY. That is a good point.

Mr. FRANK [continuing]. On a Federal level, but part of it is also done in other places that involve Federal activities.

Mr. MURPHY. Well, that is a good point. So let me look at the bottom line here because I don't want to just talk about bureaucracy and the beltway—people don't understand that.

So first I have a slide up, heart disease mortality rate. As you can see, it is going down over the last 10 years. Let us look at the next slide. Stroke mortality rate. That is going down. Next slide, HIV/AIDS mortality rate, that is going down. Next slide, auto accident mortality rate, that is going down. The next slide, cancer mortality rate, that is going down. Now, none of these are within your wheelhouse, but let us look at the next slide. Wow. Suicide mortality rate, it is getting worse.

Ms. Hyde, you just talked about these programs you have; one of them being the suicide plans, and I think you even said you thought it was having some success, but I look at this—do you intend to take any action to respond to either or both of the recommendations by GAO about the need to better evaluate and coordinate these programs?

Ms. HYDE. We have taken significant action in this arena and brought together a public-private partnership that has developed with the Surgeon General a national strategy for suicide prevention.

Mr. MURPHY. Well, they said some of these——

Ms. HYDE. It is only a——

Mr. MURPHY [continuing]. Organizations haven't met for 5 years.

Ms. HYDE. It is only a couple of years old. We are just beginning to implement——

Mr. MURPHY These organizations have been in place for a long time. The mandate of SAMHSA to meet has been in place for a long time. The GAO report says that some of these groups haven't met since 2009. Now, you said that there is a new group which has met once in January. So when you talk about coordination of these programs, I just want to deal with—we are trying to help here, but I oftentimes tell people when they come to this committee, if you want to meet a friendly Congress, come in and say, you know what, we messed up big time and we have to change this. But when you give me this litany of all these successes, and I look at that, that is 40,000 people died in this country last year. Forty thousand. One point two million suicide attempts requiring some help.

Now, if we were to also look at the employment rate among the mentally ill, it also is getting worse. You also have states saying a huge number of people in jails, increase in homelessness. I don't know where these numbers come from, but when I go around to different states, I am sure where you are from colleagues, it is a problem. So you are obligated under the law to coordinate these programs. You have the Congressional Committee that has jurisdiction over your agency. It is concerned over this lack of coordination in this area. And here the nonpartisan Government Accountability Office is concerned about this. The Assistant Secretary for Planning and Evaluation of HHS sitting next to you is concerned about this lack of coordination in this area. So are you going to take action to change this coordination, not to say we have done it in the past, everything is fine, but are you going to make further changes on coordination?

Ms. HYDE. You asked about one thing, and you made a comment about a separate thing. So we have taken significant action on suicide. We are concerned about those numbers and working on it. We have plans in place and a public-private partnership that is working to develop approaches to deal with zero suicide and health care, and other clinical guidelines and other approaches to measuring and dealing with getting people to pay attention——

Mr. MURPHY. Well, I——

Ms. HYDE [continuing]. To suicide. So we have a lot of work going on in——

Mr. MURPHY. I appreciate that, and I think——

Ms. HYDE [continuing]. Coordinating suicide efforts. You asked a different question about a different entity.

Mr. MURPHY. Well, it is all related here, and the issue too is, as Dr. Kohn also said, that at first, SAMHSA couldn't even acknowledge that suicide was related to serious mental illness is a problem.

I am out of time. I will now recognize Ms. DeGette for 5 minutes.

Ms. DEGETTE. Administrator Hyde, I will give you the opportunity to respond to the second question that the chairman asked, if you would like to, very briefly.

Ms. HYDE. Yes, we initially didn't—obviously, not everyone who has suicidal ideation, or decides that they may want to make a plan to hurt themselves, has a serious mental illness, but about 90 percent of them do have mental health issues. So when first asked was that an SMI program, we were concerned with calling it an SMI program. As we went through the work with GAO, the distinction between a program that supports people with serious mental illness versus a program that is specifically and only designated for those individuals was made, and in that case, we brought our program into the SMI tent.

Ms. DEGETTE. And actually, that is a perfect segue, Dr. Kohn, to the question I wanted to ask you, which is, you testified and your report really talked about how agencies had difficulty identifying which programs served the seriously mentally ill. Is that because of definitional problems? In other words, you might have a program that has a lot of mentally ill people it is serving, some of them serious, some of them not, by definition. Is it a definitional issue sometimes?

Ms. KOHN. It may be sometimes. We provided a definition of what we meant by program, what we meant by serious mental illness, what we meant by serious emotional disturbance, SED. We provided those definitions. So sometimes it could be that there were definitional issues and they counted the programs differently. Sometimes an agency might have rolled up their programs into 1, another one disaggregated the programs.

Ms. DEGETTE. OK, so it is. Dr. Frank, I want to ask you, throughout all of your agency's programs, is there one clear definition of seriously mentally ill that all of the different programs are broken into?

Mr. FRANK. As I mentioned in my testimony, it is very difficult to draw a line around a program and say that that is——

Ms. DEGETTE. So your answer is no, it is not specifically polled out?

Mr. FRANK. We have a definition of serious mental illness——

Ms. DEGETTE. Right.

Mr. FRANK [continuing]. So we can identify the people and we can identify the services they need, but there are many programs——

Ms. DEGETTE. But the programs aren't just separated out for that.

Mr. FRANK. The programs don't cut that——

Ms. DEGETTE. Administrator Hyde, is this true in SAMHSA as well?

Ms. HYDE. That is correct. There are multiple definitions of serious mental illness both in the law and in peoples' parlance and how they use that term.

Ms. DEGETTE. Do you think in evaluating the programs at your agencies, it would be important to make this distinction or not? Yes or no will work here if you can do that.

Ms. HYDE. For any particular program, yes. We are in the process of actually redefining SMI for purposes of the block grants because the definitions and the DSM and the standards for determining who has what diagnoses have changed.

Ms. DEGETTE. And, Dr. Frank?

Mr. FRANK. Could you repeat the question?

Ms. DEGETTE. Yes, the question is do you think it would be important to be able to more clearly identify illnesses—or treatments affecting seriously mentally ill patients, or is that impossible?

Mr. FRANK. I think the most important thing is to identify the people and then we can sort of work up to the programs——

Ms. DEGETTE. What the programs they need, OK.

One of the things Dr. Kohn talked about in her report that really struck me was that a lot of the programs throughout the Federal Government have really not been evaluated for efficacy. And I am wondering, Administrator Hyde, if you can talk about what she says, in particular, about SAMHSA, because I am a very evidence-based person. If you have a program targeted at the mentally ill in general, the seriously mentally ill in particular, one might think that you would want to have evidence that it works.

Ms. HYDE. If you look at the report, actually, SAMHSA is doing a good job at evaluating our programs. And I am very proud, actually, of the work we have done to create a Center for Behavioral Health Statistics and Quality to actually develop our capacity to do quality measurement, and to do evaluations.

Ms. DEGETTE. And so you think that kind of evaluation is important?

Ms. HYDE. Absolutely, and we——

Ms. DEGETTE. And——

Ms. HYDE [continuing]. Are doing a lot of it.

Ms. DEGETTE. And, Dr. Frank, what about through the other agencies?

Mr. FRANK. Yes, we do a tremendous amount of evaluation.

Ms. DEGETTE. OK, but a lot of your programs have not been evaluated——

Mr. FRANK. Well, actually——

Ms. DEGETTE [continuing]. Like that.

Mr. FRANK [continuing]. I think that one of the problems in the report is when you overlook 89 percent of the money that we spend,

and pretend we don't evaluate there, you miss all the evaluations we are doing. So we have lots of Medicaid——

Ms. DEGETTE. But of the ones you looked at——

Mr. FRANK. Well——

Ms. DEGETTE [continuing]. Some of them were not being evaluated.

Mr. FRANK. Some of them were not, for example——

Ms. DEGETTE. Do you intend to evaluate them?

Mr. FRANK. Well, let us take a particular example. One of the four programs that they pointed out was a technical assistance program. OK? We don't usually evaluate small technical assistance programs, whereas we do evaluate treatment programs. And so there is a distinction, and those were not brought out very clearly in the report.

Ms. DEGETTE. If you could supplement your answers with more specific——

Mr. FRANK. Yes.

Ms. DEGETTE [continuing]. That would be helpful.

Thank you, Mr. Chairman.

Mr. MURPHY. Sure thing. Can I just ask, as a clarification, because as this hearing goes on we are going to need this distinction, when Congresswoman DeGette asked about defining things for serious mental illness, and you said we should identify the people, what does that mean?

Mr. FRANK. What I think is very important to do is, as you said earlier, work from the bottom line up. So let us find the people we are worried about here, people with serious mental illness, let us look at what they need, let us look at what they are getting, and then when they are not getting what they need, let us figure out how to fix that.

Mr. MURPHY. So you are acknowledging that is not taking place right now.

Mr. FRANK. Excuse me?

Mr. MURPHY. So you are acknowledging that is not taking place right now.

Mr. FRANK. I am acknowledging that it—well, as you held out, my view of this is better but not well, which means——

Mr. MURPHY. All right.

Mr. FRANK [continuing]. We are getting better.

Mr. MURPHY. Mrs. Blackburn, recognized for 5 minutes.

Mrs. BLACKBURN. Thank you, Mr. Chairman.

Let us stay with this issue of efficacy because I think it is so important. And, Ms. Hyde, I want to come to you on this. Your strategic plan, the 2011–2014 strategic plan, does acknowledge the need for coordination to solve the problems of homelessness, joblessness, educational challenges of the serious mental ill. The GAO report says this is not taking place, so we are wanting to see where the outcomes are. So does SAMHSA believe that the present state of program staff level, as opposed to agency level coordination, within and across different agencies, and Mr. Frank talked a little bit about this, that it is adequate to achieve the GAO-approved standards of interagency coordination, despite the concerns expressed by the GAO report?

Ms. HYDE. I think we can always do better, but we do a significant amount of work with Justice, with VA, with DoD, with a number of other agencies that touch and work with our population——

Mrs. BLACKBURN. Ms. Hyde, let me interrupt you right there. Yes, you are doing work, but we are not seeing that you are achieving outcomes. Now, you get $3.6 billion a year. How much of that money, and I want a detail on this, how much of that money is going to make it down to the local and state agency level to help with these problems, and how much of that are you all keeping here in D.C. over at the agency? I want to know where this money is going and where it is meeting the need, because we are not seeing the outcomes. And you can submit that to me.

Dr. Frank, let me come to you. You say serious mental illness is a collection of problems. And yes, you have substance abuse and mental health, we understand that. Should Congress help you out on this? Should we help you and legislate a definition of serious mental illness? Do you need us to do that to help you get to the point of saying here is a problem, we can define it, here is an action item, here is what the expected outcome. Yes or no?

Mr. FRANK. I don't think there is a lot of disagreement. I think there are ambiguities around the edges, but I would say that if you and I and the chairman and the ranking member sat down, we would come to a 99 percent agreement on what we are talking about here.

Mrs. BLACKBURN. OK. Well, then let us pull Congress into this, and as we are trying to get to a point of coordination, how about working with the Energy and Commerce Committee, or perhaps keeping an open mind to GAO's recommendations rather than rejecting them outright, so that we can say here is the definition of serious mental illness, and here is what the expected outcomes are going to be to help individuals. See, I don't think we are ever going to get to mental health parity unless we can do this. We can admit there is a problem in how we address it, how we expend these funds.

So are you all willing to keep an open mind to the GAO's report say maybe we are not meeting the need, and maybe we are missing the mark on this one? Are you open-minded about that?

Mr. FRANK. Ms. Kohn?

Mrs. BLACKBURN. Each of you. Go ahead.

Mr. FRANK. Yes, OK. I am certainly open-minded to—I think the problem that we started the hearing off with that the chairman raised, which is what do we do for people on the ground, how do we coordinate their care, is absolutely something that we have an open mind about how to deal with.

Mrs. BLACKBURN. Are you open-minded to working with us——

Mr. FRANK. Absolutely.

Mrs. BLACKBURN [continuing]. To get to the bottom of this? OK, Ms.——

Mr. FRANK. Absolutely.

Mrs. BLACKBURN. Ms. Hyde?

Mr. FRANK. Can I add one other point?

Mrs. BLACKBURN. Sure.

Mr. FRANK. I think the very important thing though is we need to talk about all of HHS programs, and all the tools we have in the

toolkit in order to fix the problem, and not just focus on 11 percent of the action.

Mrs. BLACKBURN. Yes.

Mr. FRANK. We need to focus on 100 percent.

Mrs. BLACKBURN. On the total thing. I appreciate that.

Let me ask you this, Dr. Frank, I only have 24 seconds left. If we were to move to zero-base budgeting, where you start from dollar one ever year and build out your programs based on what is working, would that be helpful to you? So would you have more flexibility there?

Mr. FRANK. I was reading Robert McNamara's biography the other day. I am not sure where I stand on zero-base budgeting there.

Mrs. BLACKBURN. OK. I yield back.

Mr. MURPHY. Thank you.

Now recognize the ranking member of the full committee, Mr. Pallone, for 5 minutes.

Mr. PALLONE. Thank you, Mr. Chairman.

There are always going to be opportunities to strengthen and expand the Federal programs that serve individuals living with serious mental illness, and I know that the officials here from HHS would agree with that statement.

So I would like to learn more about the new programs and other improvements that the department has made since fiscal year 2013 when GAO conducted its evaluation, and how the department plans to expand its work in the future.

So in fiscal year 2014, SAMHSA implemented a new set-aside in the mental health services block grant requiring the states to use 5 percent of their block grant funds to support treatment for individuals in the early stages of serious mental illness.

Administrator Hyde, can you describe how states will be using that funding, and how will SAMHSA be monitoring and evaluating this initiative?

Ms. HYDE. Thank you for the question. First of all, we are very pleased with this set-aside approach. We are working with all 50 states and working with NIMH to provide guidance and technical assistance to them based on evidence-based approaches that NIMH has developed.

Some of the states get very little money out of this 5 percent set-aside because the block grant is, frankly, not enough money for the country. So to the extent that it is a very small amount, it is going to be hard to do a consistent evaluation. We are working with each state to try to make sure within their system they can identify what they are doing, and in some states, for example, they are actually putting their own money and multiplying these dollars by as much as seven times. So different states are going to have different capacity to give us, feed us back what they have been able to do with it. Some states, they will be able to train people on what the new evidence-based approaches are. And other cases, they will be able to actually put services on the ground. And in many states, Medicaid is going to pay for the actual service for some people, whereas the state will be using our dollars to evaluate, to oversee, to train, and to direct the traffic.

Mr. PALLONE. OK, thanks. In your testimony, you mentioned that many people living with serious mental illness are unemployed. And in fiscal year 2014, SAMHSA launched the Transforming Lives Through Supported Employment program to help address this problem. Can you elaborate on how this program specifically supports individuals with serious mental illness, and what other partners does SAMHSA work with on this program?

Ms. HYDE. Yes. This is a program that we work with the Department of Labor, and now within HHS because the program has moved over to the Administration on Community Living to implement an evidence-based practice that we developed through evaluation and through research and approaches a few years ago to develop a toolkit that is actually specifically for people with serious mental illness, and specifically supports them in gaining and maintaining employment.

We have seen increases in employment using that approach. And so what we are trying to do with this very small amount of transformative money is help a state figure out how to take that to scale using their multiple systems and approaches within their state. So their labor departments, their job departments, whatever departments they have that make those things and those supports available in their state.

Mr. PALLONE. OK. Last week, SAMHSA outlined additional plans to support individuals with serious mental illness in its fiscal year 2016 budget request. So I wanted to ask you if you could tell us about the demonstration program that SAMHSA has proposed to improve state and local responses to behavioral health crisis.

Ms. HYDE. Yes, thank you for that question. The crisis program which I mentioned is, again, one we are really excited about because there has been a lot of conversation about emergency rooms and appropriate use of emergency rooms, and that is the only option that people have, or people ending up in jails and prisons when they really should be getting treatment, or lack of inpatient beds, and all of that, when you look at it, surrounds the issue of how you deal with a crisis. How do you prevent it, how do you deescalate it, and how do you follow up so that it doesn't happen again, and how do you engage the family as well as the individual in managing that process.

So we are proposing a crisis services system program to try to see if we can bring those multiple funding streams and multiple systems together in a few communities to test and demonstrate how best to do that. These are multifaceted systems that have to work with that. We do have some evidence that if we do it right, we can prevent the need for so many inpatient beds, and certainly prevent the boarding and other kinds of inappropriate emergency room use.

Mr. PALLONE. Did you want to mention any other initiatives that HHS hopes to launch or expand in the next fiscal year to support individuals with serious mental illness?

Ms. HYDE. Well, we are expanding other areas for veterans' mental health, we are expanding mental health workforce issues, because that is a huge and growing issue for our ability to meet goals. And we are actually also expanding tribal mental health issues to try to make sure that we can address mental health

issues in Indian country, which have been sorely unaddressed, especially for young people who are dealing with suicide issues, bullying issues, job issues, and other things.

So we are trying very hard to focus on this transition-aged youth. We also have a healthy transitions program that we are going to continue in the next fiscal year through the President's budget. So trying to put all of that together to deal with that group or that set of young people, first episode issues and trying to prevent, as the chairman said and Ms. DeGette said, to try to prevent it from getting to be a more serious problem later.

Mr. PALLONE. Thank you.

Mr. MURPHY. Thank you. Just as a follow up to something that Mr. Pallone had mentioned, and you talked about the block grant program, I want to clarify, in your draft block grant application here, when it comes to the block grants, you actually say that these block grants—you don't talk about being for serious mental illness. In fact, you say the opposite, "it is about everyone, not just those with illness or disease, but families, communities, and the whole population, with an emphasis on prevention and wellness." That is not serious mental illness. So I want to make it clear that when you are responding to Members on this, if it is partly related to mental illness, let us know that, but don't tell us the whole thing is related to that because it is not.

Ms. HYDE. Mr. Chairman, the people with serious mental illness have been documented to have significant health problems. They die sooner——

Mr. MURPHY. Yes.

Ms. HYDE [continuing]. Than other people, and some cases with serious mental illness, years and years earlier, mostly from preventable health issues.

Mr. MURPHY. Right.

Ms. HYDE. So our wellness efforts are definitely directed toward people with serious mental illness who, we don't want them to die——

Mr. MURPHY. I——

Ms. HYDE [continuing]. And we don't want them to have diabetes.

Mr. MURPHY. I will challenge that later, but I need to get on to the next Member.

Mr. McKinley is recognized for 5 minutes.

Mr. MCKINLEY. Thank you, Mr. Chairman. And thank you for holding this hearing. I think that this is something that you have been championing for the 4 years I have been in Congress, and I really applaud you for the efforts of trying to get better attention on serious mental illness. So congratulations on continuing to move this.

But, Ms. Kohn, I have a question of you, if you could. You heard a lot of the testimony. I saw you studying those charts that showed the mortality rate dropping, and we have heard some folks here explain how they really are making progress. That is the spin of Washington.

So my question is, based on what you have heard, what you have studied, do you believe that HHS and SAMHSA have done everything they can to reduce the chance of duplication, and in par-

ticular, really supporting mental illness in this country? Do you think they are doing everything they can?

Ms. KOHN. Our report acknowledges the variety of activities they are undertaking right now, but we do believe there is room for improvement, particularly in areas related to greater interagency coordination, and greater evaluation as part of helping uncover, develop, advance the data—the evidence base for treatment of mental illness——

Mr. MCKINLEY. OK, thank you.

Ms. KOHN [continuing]. And serious mental illness.

Mr. MCKINLEY. Ms. Hyde, you appeared at this committee back in 2013, and you acknowledged apparently during that, I wasn't on the committee at the time, that some of the organizations that SAMHSA is funding may be running programs or expressing opinions that are at odds with SAMHSA. Is that still accurate?

Ms. HYDE. When we fund a program, we fund them for a specific activity. They may have positions that they take before Congress or in the press, or any place else, that they have a right to take, that is not associated with our program.

Mr. MCKINLEY. But are you funding agencies that—for example, one was apparently cited during that meeting that you were funding a group that encouraged individuals with serious mental illness to experiment going off their doctor-prescribed medicines.

Ms. HYDE. We do not fund going off medications. We do fund assistance and helping——

Mr. MCKINLEY. But——

Ms. HYDE [continuing]. People understand medications and how best to work with their doctors.

Mr. MCKINLEY. But you are funding the National Coalition of Mental Health Recovery. Dr. Fischer has put out articles about how it is designed to help people—in their literature, their newsletter, how to come off their psychiatric medicine on their own. So——

Ms. HYDE. We do not fund that organization for——

Mr. MCKINLEY. I am sorry, but——

Ms. HYDE [continuing]. Any of those positions.

Mr. MCKINLEY [continuing]. You funded it to $330,000.

Ms. HYDE. If you listen to my whole sentence, we don't fund that organization for that position——

Mr. MCKINLEY. Well, I saw you make fun of the other—so I guess I need to get—because I saw your look, and I may be deaf but I can read body language and I saw your disgust with the question asked earlier. So I am concerned that you are funding some of these programs, and I hope that you will be more cognizant, more careful about the agencies that you are funding.

I am curious about one other that I haven't seen. Is SAMHSA taking a position on the—I guess it is the medical use or maybe just the use of marijuana for relieving anxiety? Has SAMHSA taken a position on whether or not marijuana is a drug that might help people with mental illness?

Ms. HYDE. Our position on marijuana is that for young people, it is unacceptable and inappropriate in any case, in any state, anywhere. And our efforts around marijuana are primarily around prevention and dealing with underage use where the evidence shows

that it has negative educational and social and other implications for young people. Same is true of alcohol.

Mr. MCKINLEY. OK, but I am just staying with marijuana——

Ms. HYDE. That is in our effort——

Mr. MCKINLEY [continuing]. That the epidemiological studies have indicated that there is beyond a doubt that the marijuana use increases the risk of schizophrenia. Do you agree with that report that I have a copy of here?

Ms. HYDE. We are concerned about the issues with marijuana, and we are working with NIDA and with other entities within HHS to look at——

Mr. MCKINLEY. So do you fund——

Ms. HYDE [continuing]. The research issues.

Mr. MCKINLEY. Do you fund—we have such short time. You know the game here. Do you fund any organization that supports the use of marijuana as a treatment?

Ms. HYDE. I don't know the answer to that.

Mr. MCKINLEY. Could you get back to me on that——

Ms. HYDE. I don't know whether or not the——

Mr. MCKINLEY [continuing]. Please?

Ms. HYDE [continuing]. American Psychological Association supports it, and we do fund them.

Mr. MCKINLEY. OK, in the time frame that I have——

Ms. HYDE. I don't know whether or not other organizations——

Mr. MCKINLEY [continuing]. Dr. Frank——

Ms. HYDE [continuing]. Support that.

Mr. MCKINLEY. Dr. Frank, if you could, please, last week we had on a meeting here about the influenza and the vaccines, do you know of any group that the HHS is funding along the same line of reasoning, any group that we are funding that is advocating not using vaccines?

Mr. FRANK. I don't know the answer to that question. I would be happy to find out and get back to you on it.

Mr. MCKINLEY. You understand the question?

Mr. FRANK. No, I understand the question, I just don't know the answer.

Mr. MCKINLEY. Yes, OK. If you could please.

Mr. FRANK. Yes.

Mr. MCKINLEY. It would make a lot of——

Mr. FRANK. I think it is a perfectly reasonable question, I just don't know the answer.

Mr. MCKINLEY. OK, if you could get back to us and——

Mr. FRANK. Sure.

Mr. MCKINLEY. Thank you very much. I——

Mr. MURPHY. Thank you. Mr. Kennedy, you are recognized for 5 minutes.

Mr. KENNEDY. Thank you, Mr. Chairman. And I thank the witnesses again for their testimony.

I just want to put the discussion today in context, which I think is an extraordinarily important discussion, and hopefully we can try to find some ways to work together on making sure that these programs are getting to a population that needs some extra assistance.

But, Dr. Frank, I think in the HHS response letter, they put into context that—of Federal Government expenditures on mental health, Medicaid pays for about 27 percent, Medicare is about 13 percent, private insurance is about 26 percent, and all of the other programs that are subject to today's discussion are roughly 5 percent. Is that right?

Mr. FRANK. Correct.

Mr. KENNEDY. So the discussion that we are having here, as integral as it is to making sure the system works better, we are also talking about 5 percent of the overall mental health spending in this country. So if we are looking at a much more systemic approach, one would say we should also focus on the 95 percent of the rest of that funding, and how to reform that delivery system and make sure that care is much enhanced. Is that fair to say?

Mr. FRANK. Yes. I think that is exactly the point I was making, not to in any way diminish our need to pay attention to the 5 percent, but the other part, the other 40 percent really needs attention, and that is why our integration efforts on Health Homes, on duals, on expanding SNPs, on expanding case management, are so important because they happen in that other part.

Mr. KENNEDY. When I am back home, Doctor, I hear all the time about lack of beds, lack of availability at doctors, lack of wraparound services. It strikes me that a lot of that has to do with incentives and the way the Federal Government reimburses doctors, hospitals, clinicians that are working in this field. You align those incentives properly, you are going to get the beds, the treatment facilities, the incentives for doctors to treat. Is that fair to say?

Mr. FRANK. I am an economist and I believe that.

Mr. KENNEDY. OK, thank you.

So with that as context, I do want to go back to the basis of the report for a quick minute. The report indicates, "that coordination specific to serious mental illness was lacking among interagencies, committees," but it goes on to say that, I believe again, "staff from 90 percent of the programs targeted serious mental illness reported coordinating with the counterparts in other programs."

The coordination we are talking about doesn't happen because it is legislated, it will only be enhanced if there is a cultural change at some senior staff level, and a willingness to implement both the letter and the spirit of the law.

Dr. Frank, how can we engage senior staff, and does that interaction at the staff level suffice, or is more senior staff interaction necessary? We will start with you and go from there.

Mr. FRANK. I think your point about culture is very important, and I think this Administration has been extraordinarily attentive to building that culture. Administrator Hyde has had a central role in that, taking steps to reach out far beyond their 5 percent there into Medicaid and into other areas. Our Secretary is extraordinarily supportive of these matters. And so the result is we have tremendous amount of joint activities with HUD, with SSA, with Labor, with Treasury, et cetera, and it is really those types of focused working groups across the government that have really, I think, improved our ability to coordinate with in a variety of problem-specific areas.

Mr. KENNEDY. Thank you, doctor. I will just stop you there because I have about a minute left. And, Ms. Hyde, if you have a response to that.

Ms. HYDE. I think I would just echo Dr. Frank. The recommendation that was made was about a specific type of infrastructure that we think isn't going to be the best way to address the issue on the ground. So that is the distinction we are trying to make here, that we have a lot of coordination going on, we believe in coordination, but the particular recommendation and the approach seems just like more bureaucracy.

Mr. KENNEDY. So if creating that or strengthening that interagency working group from the senior level isn't the right way, and understanding that you are pushing coordination now, I realize I only have about 30 seconds, but what would you suggest, in 30 seconds, to really push that out to the lowest levels on the ground and try to enhance that coordination even more so? I think it is hard to debate the fact that that is needed.

Ms. HYDE. I think it is multifaceted. We have to have person-to-person interactions, we have to have working groups on specific issues as what we described, we have to have staff-to-staff level programmatic interactions, and we have to push our grant programs to require coordination at the state and grantee level. So we are doing all of those things, and trying to bring that together where it works on the ground for individuals.

Mr. KENNEDY. Thank you. I yield back my extra 7 seconds.

Mr. MURPHY. Do you want Dr. Kohn to also answer your question too because she didn't get a chance to answer——

Mr. KENNEDY. Yes, if you don't mind.

Mr. MURPHY [continuing]. That question?

Mr. KENNEDY. Thank you.

Mr. MURPHY. Dr. Kohn?

Mr. KENNEDY. Please.

Ms. KOHN. OK, sure. Thank you. I don't think what we are putting out here is an either/or, that if there is coordination at a local level that, therefore, coordination at the Federal level is unneeded, or vice-versa, that coordination at the Federal level will supplant the coordination that happens at the local level. I don't think there is that kind of a trade-off. And the concerns we were raising about lack of coordination at the Federal level inhibits our understanding of the Federal footprint in this area. What are the programs in place, recognizing that there is a lot there in Medicare and Medicaid and Social Security, as the OMB letter in response to this committee had shown, but we didn't start from that spending side. We started from the programs, the population served. As Dr. Frank noted, people don't fall into neat program categories, and that is why that coordination becomes so important because that coordination helps identify if there is any potential overlap or duplication, are there gaps, are there programs that are complementary that aren't being linked together, need some stronger linkages so we maximize our existing resources in our existing programs. If it is a gap and nobody is looking at it right now, then how does the coordination happen? It is by definition not visible.

So the coordination we talk about is not instead of the coordination at the local level, it is in addition to.

Mr. KENNEDY. Thank you. Thanks for the extra time.

Mr. MURPHY. Thank you. Mr. Griffith, you are recognized for 5 minutes.

Mr. GRIFFITH. Thank you, Mr. Chairman. And I appreciate having 5 minutes, but I wish I had a lot more. I would like to get the information that Mrs. Blackburn asked for earlier in regard to the money as it flows to the state and local levels as well. So when you report to her, if you could make sure I get a copy of that, I would greatly appreciate it.

I am going to need some yes-or-no answers because I have to fly through this because of the time limitations that we do have. But GAO noted that SAMHSA officials did not initially include any of their suicide prevention programs among those that can support individuals with serious mental illness. Isn't that true, Ms. Hyde, yes or no?

Ms. HYDE. I explained why. Yes.

Mr. GRIFFITH. And SAMHSA explained to GAO that the suicide prevention services it administered were not limited only to individuals with serious mental illness, and served a broader population. That is also true, isn't it? Yes.

Ms. HYDE. It does serve a broader population.

Mr. GRIFFITH. And at the subcommittee's hearing on suicide prevention held last September, the Chief Medical Officer of the American Foundation for Suicide Prevention noted that in more than 120 studies of completed suicides, at least 90 percent of the individuals involved were suffering from a mental illness at the time of their deaths. And I thought I heard you say earlier that you agreed with that number, is that correct?

Ms. HYDE. That is correct.

Mr. GRIFFITH. And my one concern there is that, of course, we had the 10 percent. Would you also consider that 90 percent to be serious mentally ill, yes or no?

Ms. HYDE. I don't think researchers think that that is all serious mental illness as it might be defined in a functional level.

Mr. GRIFFITH. But it is pretty serious when somebody ends up dead, isn't it?

Ms. HYDE. Absolutely. That is why we had the——

Mr. GRIFFITH. All right.

Ms. HYDE [continuing]. Conversation about——

Mr. GRIFFITH. And——

Ms. HYDE [continuing]. What to include in——

Mr. GRIFFITH [continuing]. After further discussion with GAO, SAMHSA included its suicide prevention programs, among those that can support individuals with serious mental illness. Isn't that also true?

Ms. HYDE. I am sorry, can you repeat that question?

Mr. GRIFFITH. I can. After further discussion, you then submitted the suicide prevention programs, among those that can support individuals with serious mental illness, even though earlier you had not included them because you thought it was a broader audience. Isn't that true?

Ms. HYDE. We were trying to understand——

Mr. GRIFFITH. Yes or no.

Ms. HYDE [continuing]. What GAO wanted, yes.

Mr. GRIFFITH. OK. And DoD officials initially identified all of their suicide prevention programs as supporting individuals with serious mental illness. Do you think that there might be some institutional bias on the part of SAMHSA in favor of dealing with mild as opposed to more severe behavior or health conditions that make it more difficult for SAMHSA to recognize and act upon the unique nature and impacts of serious mental illness or serious emotional disturbances?

Ms. HYDE. Goodness, no. We were trying to be honest and fair about the answer to the question.

Mr. GRIFFITH. All right. And I appreciate that.

Here is the reason that I am so concerned on these issues, and while I recognize that you all have said previously that it is getting better but it is not fixed, I do appreciate that. I was a, what we call in our neck of the woods, a street lawyer for many years. I can still see the eyes of the mother who dealt with, while she was a client of mine, for years her paranoid schizophrenic son who ultimately committed suicide. I can see a former client standing in the courthouse with his son crouched on a bench because he was back into the court system, not in the mental health system but the criminal court system, yet again, and not knowing what to do. I can see the faces of the deputies as they started to go out of the building to deal with a verbal fight in the parking lot of the courthouse where a son and a father were having a verbal altercation after a hearing in the criminal court system, and I had to advise the deputies to back off because of the mental illness of the son. He would have a violent reaction to the uniforms, not to the individuals but to the uniforms, but he would not be violent with his father, and they agreed to do that. And then my wife, who continues to practice law although I have come here now, last week was dealing with, in the juvenile system where she is a practitioner and a substitute judge, dealing with a child who attempted suicide, having a serious emotional disturbance, learning that they couldn't deal with one plan that the hospital had come up with because he hadn't been hospitalized twice in the last year, he had only been hospitalized twice in the last 13 months. And when I said are there questions, I have HHS and SAMHSA coming in, are there questions I should ask about what we are going to do about this child who is someone I know, and who may very well end up being successful at some point if we don't do it right. I said are there questions I can ask, and her response was, no, they don't have anything to do with this.

I ask you, do you believe that you all need to be coordinating to such an extent that experienced practitioners in law would know that you have something to do with it when there is a suicide attempt, or that there might be a program to help? I asked those questions. Nothing came back. And I noticed in your report that you had something on the Garrett Lee Smith Youth Suicide Prevention Program listed in the GAO study, and I texted my wife and I said any of the contacts related to any of the cases you have done in juvenile court for the last 16 or 17 years, have you ever heard of this. Answer is no. So I present you with this indictment, and I hope to get some response at a later time because my time is up.

And I yield back.

Mr. MURPHY. Thank you.

Now recognize Mr. Tonko for 5 minutes.

Mr. TONKO. Thank you, Mr. Chair.

Dr. Frank, has the failure of some of our states to expand Medicaid eligibility in accordance with the Affordable Care Act affected in any way the ability to treat those with mental illness or mental health disorders?

Mr. FRANK. Indeed it has. Just to give you a flavor. Among people with serious mental illness, in 2010 for example, call that the before period, nearly 21 percent of them were uninsured and they were disproportionally low-income. And so, in fact, the states where you are seeing expansion are getting more of those people covered than the states that aren't. That opens up a lot of new opportunities for treatment because, as you know, Medicaid offers a broad package of services that are specifically, in many cases, tailored to people with serious mental illnesses.

Mr. TONKO. Yes. And would you have any data that are directly speaking to the mortality rates in those states that you could provide to the committee?

Mr. FRANK. I think it is too early to tell now, but just so you will know, we are doing an evaluation of the Medicaid expansions, and we are doing segments of that evaluation that focus specifically on vulnerable populations like those with serious mental illness.

Mr. TONKO. Yes. And if I could ask the three of you, and I will start with Dr. Kohn, how do you define serious mental illness?

Ms. KOHN. In our report, we used scientific definitions that we worked with SAMHSA to develop. It includes conditions such as major depression, bipolar disorder, schizophrenia, PTSD. We used a definition that goes about half a page of a footnote. It is a scientific definition.

Mr. TONKO. OK. Dr. Frank?

Mr. FRANK. Well, rather than give you the science, I will give you something that most of us would believe in common parlance. So typically, I think schizophrenia, bipolar disorder, major depression, some forms of major depression, some forms of trauma, PTSD, and a variety of other things depending on their functional capacity is what I think we typically think of serious mental illness.

Mr. TONKO. And, Administrator Hyde?

Ms. HYDE. Generally, it is a combination of diagnosis and functioning and history. So you generally have to look at all three of them to see what the functioning level is. The diagnosis is important but not in and of itself enough.

Mr. TONKO. And so, therefore, is serious mental illness a static state?

Ms. HYDE. Not necessarily.

Mr. TONKO. OK. Well, there has been a lot of emphasis today on SAMHSA's work on treating mental illness, and specifically serious mental illness, but we need to keep in mind, I believe, that these individuals represent a small portion of the overall population living with mental illness. And we also need to keep in mind that we will be more effective with these patients by treating them early in the course of their illness, and perhaps altering the trajectory of their condition, rather than reacting to crisis situations that arise time and time again. SAMHSA plays an important role in the

prevention and early detection of serious mental illness, and I have seen that in programs that reach my district.

So, Administrator Hyde, can you discuss some of the ways that SAMHSA supports the prevention and early diagnosis of serious mental illness?

Ms. HYDE. Yes, thank you for that question. One of the ways we are doing that is to implement the RAISE Program, which is the evidence-based practice that NIMH has developed, that is interventions both medical and psychosocial interventions done at an earlier point in the trajectory of an illness after a first episode. We are doing a lot of work in that area. We are also starting to look at what is called the prodrome, or prior to the first episode. NIMH is beginning to work in this area, and we are working with them to try to identify what would be the best way to look at that issue.

We are also looking at healthy transitions, or the transition that young people have from age 16 or so to 25, which is where a lot of this early first episode happens, and we are trying to put programs on the ground to make sure that those families and those young people are supported as they move into adulthood. And so there are a number of programs like that where we are trying to get upstream. We are also doing a lot of jail diversion work, trying to make sure that individuals who may be headed for jail because of a mental health issue can be diverted into treatment and to appropriate community-based supports instead of jail. Same thing is true with homelessness. People who are homeless on the streets with serious mental illness, if we can get them housed in evidence-based supporting housing programs we can see very good trajectories, reduction of emergency room use, et cetera.

So we have pieces of all of those kinds of programs working with our colleagues and other departments.

Mr. TONKO. I thank you. And I believe we should not lose sight of the agency's other critical activities, and how they advance your mission as well. So I thank you all for your responses.

I yield back.

Mr. MURPHY. Thank you. And we are glad you moved forward on that program with RAISE. We know it is something that this committee has raised, the appropriators funded it, and we are glad you followed through on what Congress told you to.

I now recognize Mrs. Brooks of Indiana for 5 minutes.

Mrs. BROOKS. Thank you, Mr. Chairman, and thank you for holding this hearing.

In August of last year, I held a mental health listing session in Hamilton County, just north of Indianapolis, Indiana, and pulled together advocacy groups, family groups, doctors, and luckily, head of our state HHS component FSSA as a psychiatrist, Dr. John Wernert, and he participated in this session. And we talked about the pressing issues of mental health in our state and in our country, and ways that Congress could respond. And I have to tell you, a theme of that was the fragmentation issue. And even now, as still a relatively new Member of Congress, I am amazed at the number of people with mental health issues contact our offices, and come to our events, including recently a young woman who brought to a public meeting stacks and stacks and file folders of her correspondence with different agencies, trying to seek help for her

schizophrenia. And it broke my heart. And then when I read this GAO report about the fragmentation, and would just ask all of you to look once again at the chairman's chart, and I would ask you to take that back to SAMHSA, and I applaud GAO for putting together, or attempting to put together, the comprehensive inventory, but if healthy people in a discussion have a hard time getting through the bureaucracy, how do mentally ill people and seriously mentally ill people get help?

And so, Dr. Kohn, why was it such a challenge in GAO's opinion to identify all of these different programs? What happened?

Ms. KOHN. I don't think it had been asked before, so OMB had identified where the spending was from the budget documents. I think this was one of the first times that the agencies were being asked, and so it took a lot of conversation. There was a lot of back-and-forth. We had to develop a questionnaire and go agency by agency by agency, and work with them to try to get the information.

So I think to some extent, they hadn't been asked that before, at least not the folks we were talking to.

Mrs. BROOKS. If I could, there was an organization called the Federal Executive Steering Committee that you pointed out in your report that was in place after another analysis of our mental health system early in the 2000s, and it was in place from 2003 until 2008, and it seemed to bring together at very high levels the many agencies we are talking about, but it was disbanded or has not met since 2009. Is that correct, Dr. Kohn?

Ms. KOHN. That is correct. It hasn't met since 2009.

Mrs. BROOKS. And so, Ms. Hyde, you indicate all of this coordination, but it seems to be at the highest levels only within HHS, is that correct? Why was that disbanded? Why was the Federal Executive Steering Committee, which brought together at the highest levels, why was it disbanded?

Ms. HYDE. The Steering Committee had accomplished a lot, but much of the coordination work had moved into the programmatic area.

Mrs. BROOKS. What do you think it accomplished? When we have seen the growing numbers, what did it accomplish and why would it disband?

Ms. HYDE. Well, I think it had difficulty solving the problem. I think that is our whole point, is one Federal, high-level coordinating body by itself is not going to solve the problem.

That group did identify programmatic areas where coordination needed to happen, and that began to happen at the programmatic level. We haven't talked at all about what the issue beyond coordination is, which is the lack of services, the lack of support, and then as we are getting more people able to get access to coverage and services, then that is going to be a much bigger and more appropriate way to get services to people.

Mrs. BROOKS. Well, and I would agree that there are a lack of services and a lack of support, but when there are billions of dollars being spent, and I guess I want to ask you, Dr. Frank, because you talked about, and my time is running short, you talked about populations and programs specific to populations, well, what if you are a middle-aged woman who is not a veteran, who is not a young

person, who is not homeless, who is not in the workplace, what programs are there for people who don't fit into these populations?

Mr. FRANK. Thank you. I actually start in exactly the same place you do with a broken heart for these people and families that face these problems, and have trouble navigating their way through the system. I think that is exactly it. I think where we were uncomfortable with the GAO report was that there wasn't enough attention paid to that question you just asked which is, we have been trying to build health homes, we have been trying to build patient-centered medical homes so that there would be a place that people could rely on to help them navigate the system, get them through, and make sure their care is coordinated across the realm. And that is really a lot of the places we have been putting our investments in, coordination.

Mrs. BROOKS. Thank you. My time has run out. We have, obviously, much work to do.

I yield back.

Mr. MURPHY. Thank you.

Now recognize Mr. Yarmuth for 5 minutes.

Mr. YARMUTH. Thank you, Mr. Chairman. I thank the witnesses for their testimony.

Anybody who has been in this job for any period of time understands the extent to which mental illness impacts our various communities and the country as a whole. Tens of millions of people affected. And clearly, we have made progress. I was proud to have supported the Mental Health Parity Act that has made an enormous impact, and obviously embodying that in the Affordable Care Act with the expansion of Medicaid, in my state has made a remarkable difference. And, you know, I don't think any of us would disagree with the notion that coordination is important, and evaluation of programs is important. We also can't lose sight of the amount of resources that are committed to these kinds of activities. And I am a member of the Budget Committee and I have seen how budget cuts have affected many areas of our social safety net and our human services initiatives. Now we are down the return of sequestration in October of this year, and we had an experiment with it a couple of years ago.

Dr. Frank and Administrator Hyde, would you talk to us about the impact of sequestration potentially on the treatment of mental illness throughout the country, and what happened a couple of years ago, what impact, if any, there was and what the new potential cuts are and how they could impact the same kind of care?

Ms. HYDE. I can talk first about SAMHSA because that is the thing I know the best. But certainly, cuts in programs have made us tighten, it has made us do less grants, so less ability to help communities out there, less ability to do new programs. The one set of new programs we have been able to do is in the President's Now is The Time plan, which I described. It also, frankly, makes us take a second look at how much money we spend on things that are not services, so it does make us tighten our evaluation efforts at times, and it just overall makes us deal with a system that is already significantly underfunded compared to a lot of the other, heart disease and other mortalities that we are trying to deal with. So I actually could give you some comparisons between how much we spend for

certain of these diseases and the numbers of people that we have associated with them, and I think you would be able to see what those impacts of those dollars are.

Mr. YARMUTH. Dr. Frank, you want to comment?

Mr. FRANK. I would agree with that. I do think it has hurt our evaluation efforts a bit. I also think it shows up in exactly some of the places we have been talking about here because we work with HUD on supportive housing, we work with Labor on supportive employment type of activities, and for each of those we have had to scale back. And so, for example, our plans to end chronic homelessness by next year have had to get scaled back because the number of housing vouchers has been scaled back.

Mr. YARMUTH. All right, thank you for that. Going back to the question of evaluation for a minute, Dr. Kohn, I haven't read the GAO report but it seems to me that it might be very difficult to accurately assess some of the efficacy of these programs because, say you are dealing with a homeless vet with PTSD, the program may be able to prevent that vet from committing suicide, but certainly hasn't cured his mental illness. Do you have a model for evaluation of an efficacy of serious mental health programs in the GAO report, and I guess I would ask if you do, then I would have Dr. Frank and Ms. Hyde comment on whether this is a problematic thing.

Ms. KOHN. The report doesn't tell the agencies in this area to evaluate all of their programs all the time. We say that the agencies need to prioritize which programs should be evaluated and what is a time schedule for that, because they are costly, they are time-consuming, and so we are just telling the agencies to prioritize which programs do need to be evaluated.

Yes, GAO has a number of reports and guidance that it has issued in terms of best practices for evaluation. It includes having an outside agency doing the evaluation, identifying best practices, what works, what doesn't work in the program, making recommendations that the agency can act on in terms of how to improve the program. So there is guidance there. The other piece of the evaluation, of course, is leadership in driving the evaluation, asking the question and hearing the answer.

Mr. YARMUTH. My time is up, Mr. Chairman. I yield back. Thank you.

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

Mr. MULLIN. Thank you, Mr. Chairman.

If you could, could you put that up for me? Ms. Hyde, do you recognize what this is here?

Ms. HYDE. Yes, it is a—yes.

Mr. MULLIN. It is a screenshot from SAMHSA's Web site. I believe it is called building blocks for a healthy future, is that correct?

Ms. HYDE. That is correct.

Mr. MULLIN. Can you briefly tell me what that Web site does?

Ms. HYDE. It engages young people and their parents in emotional health development. We do have a responsibility to do prevention——

Mr. MULLIN. What is the ages——

Ms. HYDE [continuing]. In young people.

Mr. MULLIN [continuing]. For that?

Ms. HYDE. I don't remember off the top of my head the complete age range, but it is the younger——

Mr. MULLIN. It is for substance abuse——

Ms. HYDE [continuing]. It is the younger kids.

Mr. MULLIN [continuing]. For young children from the age of——

Ms. HYDE. Yes.

Mr. MULLIN [continuing]. Three to six——

Ms. HYDE. Yes.

Mr. MULLIN [continuing]. Which I am sure that is a high number that we have to deal with. I mean I have five kids from 10 years to 4 years old, and I am sure there is a high rate of substance abuse for 3-year-olds, yet do you know how much money we have spent on that Web site?

Ms. HYDE. Actually, the science tells us that the earlier we start——

Mr. MULLIN. No, I——

Ms. HYDE [continuing]. The better.

Mr. MULLIN. Do you know how much money we have spent on——

Ms. HYDE. I don't know that off the top of my head. I can tell you——

Mr. MULLIN. Ma'am, you are the administrator.

Ms. HYDE [continuing]. Though that is important that we are——

Mr. MULLIN. Ma'am——

Ms. HYDE. We are——

Mr. MULLIN [continuing]. You are the administrator——

Ms. HYDE. Yes.

Mr. MULLIN [continuing]. And you don't know how much that Web site costs. Because I went through that last night, and there is a whole bunch of songs on there which are all knock-offs of Old McDonald and Yankee Doodle, and I have a 3-year-old and I couldn't keep her attention for no time at all on that. And guess what, you have had 15,000 visitors, that is it, to that Web site for an average of 3 minutes, at a cost of $436,000. Now, do you think that is using taxpayer money wisely?

Ms. HYDE. Actually, we are going through a——

Mr. MULLIN. No, ma'am, that isn't what I asked you.

Ms. HYDE [continuing]. Something we call——

Mr. MULLIN. I said do you think that is a good use of taxpayer money?

Ms. HYDE. I don't know. Please let me finish the question and I will tell you. We are actually going through our Web sites right now. This is one of them. It is on the list to re-examine——

Mr. MULLIN. Going through, ma'am——

Ms. HYDE [continuing]. Whether or not——

Mr. MULLIN [continuing]. The money is already spent. Was it a good use of taxpayers' money? $436,000.

Ms. HYDE. I——

Mr. MULLIN. A total of 15,000 visitors. In Oklahoma alone, that would provide 176 outpatient services for the mental ill for a full year.

Ms. HYDE. That is what we are assessing and evaluating right now. We are going through each of those Web sites to determine whether or not they are appropriate or need to be continued, or eliminated or otherwise dealt with.

Mr. MULLIN. How long does it take, ma'am, because we are continually putting money in there? We are managing the Web site. And what we want to do is efficient and be more efficient.

We have heard throughout this entire hearing that we are here to help. We understand there is an issue, but what has happened is we are running into a roadblock, and instead of you admitting that there is a problem, what ends up happening is you get defensive about it. That is not helpful. That doesn't prevent anything. All that does is cause a division between us. We are not here to make you look bad, we are here to find out and see if you are being efficient with the money being spent. And so far what I am finding out is no, no, it is not. It is not being efficient.

I have a big stake in this. I have five kids that go to school every single day. These are real issues facing every parent out there, and yet we are wasting money on a Web site, or putting money out here, $436,000, you don't even know how much you have spent, and you can't even tell me if it is being efficient. Instead, you are saying you are going through it and evaluating. We have heard that over and over again today. We are going through it, we are going through it, we are going through it. You know what, as a business owner, if everything I was being evaluated on, I was having to go back and re-evaluate it, I would deem that as a failure. Maybe it is time to relook at the whole program and say is it really delivering the services, is it really coordinating with officials on the mentally ill. So far what I have heard, the answer to that is no, absolutely not.

Dr. Kohn, you had mentioned, let me find it here, you noted that part of the problem with tackling serious mental illness is the Steering and Coordinating Committees that has been established to handle the response to the mental illness over the past decade are no longer active or focused mainly on substance abuse. Is that correct?

Ms. KOHN. That is correct?

Mr. MULLIN. OK. I yield back. Thank you.

Mr. MURPHY. Thank you.

Now recognize Ms. Clarke for 5 minutes.

Ms. CLARKE. Thank you, Mr. Chairman. And I thank our witnesses for sharing your expertise with us this morning.

My first question is to Dr. Frank. Unfortunately, many states have refused to expand Medicaid coverage under the Affordable Care Act, and according to the American Mental Health Counselors Association, nearly 3.7 million uninsured adults with serious mental health and substance abuse conditions will not be covered in states that failed to expand Medicaid. To me, that decision is astoundingly shortsighted.

Dr. Frank, why is Medicaid expansion so critical to this population?

Mr. FRANK. Well, in the Chairman's opening remarks, he made a very strong case outlining how people experiencing serious mental illnesses have their work disrupted, have their education dis-

rupted, have their functioning disrupted. And so people who have trouble attaching to the workforce, attaching to the mainstream of society, tend to have low incomes, tend to rely on public programs like Medicaid. And so people in those circumstances have a chance to get the best evidence-based treatment if they are covered by Medicaid, whereas if they aren't, those chances are much lower. And so I think that is why it is so important.

Ms. CLARKE. Thank you, Dr. Frank.

I want to switch over to Administrator Hyde and ask a bit about living in a community setting. The report doesn't mention the Americans With Disabilities Act, the Olmstead decision, and how SAMHSA has been in the forefront of pushing for a service system where people with serious mental illness can live in a most integrated community setting. How does SAMHSA work to help people with serious mental illness living in the community?

Ms. HYDE. Thank you for the question. We have taken a leadership role with a number of other Federal agencies both within HHS and outside, DOJ, Office of Civil Rights, to look at the Olmstead decision and try to implement it, and try to help states understand what they can do. We try to look at the housing needs and how people can develop housing, we try to look at the employment needs and income needs and how people can develop that, and we try to look at the social supports that individuals need in the community, and we provide training, and sometimes we call them policy academies, bringing states together so they can learn from each other, and trying to make sure that they have the information they need and the program designs that they need, because there are evidence-based practices to try to develop that. We also try to bring things like HUD vouchers and other kinds of resources to the table that SAMHSA coordinates with but doesn't control.

Ms. CLARKE. Well, that model is one that I think, particularly in a place like New York City where I am from, is a preferable one. There seems to be a reliance on the criminal justice system to sort of be that community living environment, and we have found that there have been a lot of challenges within our city's jail systems, for instance, with individuals who have been incarcerated and not treated, and the conditions under which they have had to live have really compounded their illnesses. So I want to commend you for your vision here, and make sure that as we go forward, we look at a broader view of practices that do work. It is unfortunate that the report didn't mention it.

I wanted to circle back. I know my colleague, Mr. Tonko, spoke to intervention, particularly in preventing recidivism. I want to talk about early intervention for children, and get a sense of the work of the programs that you are doing through SAMHSA in early intervention. Could you speak to a little bit of that as well?

Ms. HYDE. Yes, thank you again for the question. If you are talking about young children, we have a program called LAUNCH——

Ms. CLARKE. Yes, young children.

Ms. HYDE [continuing]. Which is for zero to 8-year-olds.

Ms. CLARKE. Yes.

Ms. HYDE. Specifically to build emotional health development and to look at early needs that might be emerging there. We have some new work that we are doing on the framework of Now is The

Time to try to look at working with schools and communities to be able to identify emerging behavioral health issues before they become an issue. We have other prevention activities that IOM helped us look at, the Institute of Medicine, a few years ago, and bringing both behavioral health—well, substance abuse and mental health, because they often go together, so issues like what is happening in schools, bullying, parenting, bringing multiple systems together to help make sure that young person is able to grow and develop in a positive way. We are also doing a significant amount of work on trauma because we understand increasingly what trauma does to young people, and how it creates, actually, adult problems. We are also looking at the fact that, frankly, most adult behavioral health issues start before the age of 24, and in fact, ½ of them before the age of 14. So the younger we can start, the better we can build skills and resiliency, capacity, moving into adulthood.

So we do a fair amount of that work. As I said earlier though, ¾ of our dollars actually go toward persons, at least in our mental health environment, goes to persons with serious mental illness.

Ms. CLARKE. I thank you for your work, Administrator.

And I yield back. Thank you, Mr. Chairman.

Mr. MURPHY. Now recognize Mr. Collins for 5 minutes.

Mr. COLLINS. Thank you, Mr. Chairman.

If you could, Ms. Hyde, just kind of keep the questions as brief as you can because of the time. I am going to start with a fairly simple one. Could you give yourself a grade of 1 to 10 on how good a job you are doing?

Ms. HYDE. Tens being good?

Mr. COLLINS. Yes.

Ms. HYDE. I think we are doing 10. I think we have a lot——

Mr. COLLINS. OK, you are a 10.

Ms. HYDE [continuing]. More work to do.

Mr. COLLINS. That is pretty arrogant in my book, but we will put that aside. So you have said you are underfunded, you need more money, so I am just going to dive right in and say, as you have looked at programs the last couple of years, which ones you have just said here, you are going to look at this. How many programs have you looked at and terminated because they weren't a good use of taxpayer funds in the last 2 years?

Ms. HYDE. We actually have several programs that have been proposed for reduction, some of which Congress has reduced, and others of which have continued to be funded.

Mr. COLLINS. Could you give me a list, if you could, of those that are being recommended and those that have actually had their reductions?

Ms. HYDE. OK.

Mr. COLLINS. And when you say you are underfunded, are you constantly looking at and evaluating each program like the one that Representative Mullin said $436,000, which I think it is pretty obvious was wasted money? Are you looking at those, and who is doing that evaluation?

Ms. HYDE. Yes, if you look at the GAO report, I think you will see that SAMHSA is actually doing more than——

Mr. COLLINS. Who in your organization? Do you have like certain people?

Ms. HYDE. It depends on the situation. In some cases——

Mr. COLLINS. Well, either you do or you don't——

Ms. HYDE [continuing]. We do it internally.

Mr. COLLINS [continuing]. Have certain people.

Ms. HYDE. Some cases ASPE does it, and other cases——

Mr. COLLINS. Who is going to evaluate this sing-along program?

Ms. HYDE. Well, as I was trying to explain, we are starting the process of evaluating——

Mr. COLLINS. No——

Ms. HYDE [continuing]. That.

Mr. COLLINS [continuing]. Who? Who will evaluate that, how quickly will it be evaluated, and when could you provide this committee an answer on whether that program will be terminated and that money, since you are underfunded, redeployed?

Ms. HYDE. We will be glad to answer that question for you.

Mr. COLLINS. And when will I expect that answer? I mean you are a 10, so it should be tomorrow. Is that fair if you are a 10? If you were an 8, I could give you a week or so but since you are a 10, is it fair to say you could get that to me tomorrow? Who is going to evaluate it, when will we get the answers? I am just asking you, can I get that answer tomorrow?

Ms. HYDE. We will get you an answer as soon as we can.

Mr. COLLINS. I guess the answer is no. Well, I think you just went from a 10 to about a 7.

As I look at doing evaluations, best practices, are you identifying best practices that other states can learn from? Like this state, this program in South Carolina is exceptional, they are really working well, let us roll this out across the country. Are you identifying actively best practices to assure that taxpayer money is being well spent, and since you are underfunded, it is even more important?

Ms. HYDE. Yes, we have a registry of evidence-based practices that we are actually in the process of redoing because we need to do a better job on that.

Mr. COLLINS. You need to do a better job, but you are a 10, so that is interesting. Can you provide me a list of the best practices that you have identified, very specific, not just general let us all do better, specific best practices that you have shared with other agencies? Could you get that to me tomorrow? You said you already have a list, could you get that to me tomorrow?

Ms. HYDE. We will do our best to get it to you as soon as we can. I don't——

Mr. COLLINS. So you can't get it to me tomorrow. You just jumped from a 7 to a 5. I am asking for direct answers. You said you have it. If you have it, you should be able to get it to me at 1 o'clock this afternoon. So either you do or you don't have it. Do you have it?

Ms. HYDE. We have the list. I don't know if I can——

Mr. COLLINS. So can you get it to me today?

Mr. MURPHY. Well, let us——

Ms. HYDE [continuing]. Do some electronic version——

Ms. DEGETTE. Mr. Chairman——

Mr. MURPHY. Well, let——

Ms. DEGETTE [continuing]. We have a standard practice in this committee——

Mr. MURPHY. We will expect that.

Ms. DEGETTE [continuing]. For witnesses to respond to questions.

Mr. MURPHY. Thank you.

Mr. COLLINS. Quickly and directly. I am just saying, do you have it?

Ms. HYDE. I can get you a list of what we have, yes.

Mr. COLLINS. Tomorrow?

Mr. MURPHY. I think she said she will get——

Ms. DEGETTE. Mr. Chairman——

Mr. MURPHY [continuing]. That. We will expect that——

Ms. DEGETTE [continuing]. We have a standard practice, I would ask—I would urge all of the Members——

Mr. MURPHY. Yes, I——

Ms. DEGETTE [continuing]. Of this committee to hold to that standard practice——

Mr. MURPHY. That is OK. We will expect that information. OK.

Ms. DEGETTE [continuing]. And to respect the witnesses.

Mr. COLLINS. Yes, and I would appreciate more direct answers. I haven't actually had too many employees or witnesses who would say they walk on water, and on a scale of 1 to 10 are a 10, so I am just taking you at your word. I thought you were going to tell me you were an 8. I am surprised at the 10.

So all I am suggesting is best practices work. You say you are underfunded. We have an example here of $436,000 that I think, generally speaking, will come back, and I would like that as quickly as possible, as wasted taxpayer money that could been redirected elsewhere. So I would appreciate a prompt response as soon as you can get it to me, and that would be my request.

And I yield back.

Mr. MURPHY. Thank you. We are going to do a second round of questions here. I know some Members are coming back—Mr. Cramer is here now. All right then, we will have Mr. Cramer. Go ahead, I will recognize you for 5 minutes.

Mr. CRAMER. Thank you, Mr. Chairman, and thank you to the witnesses.

I just have one question for Ms. Hyde I was reading the HHS budget justification, and in your opening, I think you said something to the effect that—and maybe you could tell me what you said, what percentage of the SAMHSA budget was dedicated last year to SMI?

Ms. HYDE. SAMHSA's budget is in four buckets. Generally speaking, we talk about the substance abuse part of our——

Mr. CRAMER. Right.

Ms. HYDE [continuing]. Budget as being a little less than 70 percent. So the vast majority of our budget is substance abuse. Of the 30 percent or so that is mental health, ¾ of that goes to serious mental illness.

Mr. CRAMER. That is what I thought—OK, thank you for that clarification. Because in the budget justification put out by HHS where it talks about SAMHSA, it never mentions serious mental illness. Can you reconcile that omission with the commitment that you are talking about today? That just seems like somebody is not as committed to it perhaps as you are. Or am I mistaken? Because

I couldn't find it. I couldn't find any mention of SMI in the budget justification from HHS.

Ms. HYDE. The particular programs that there are some programs that are very specifically for serious mental illness or serious emotional disturbance. That is the general rubric. The block grant programs are that. It is a huge program. What we talked about, the primary behavioral health care program is specifically for that. A number of other of our programs we have already talked about serve people with serious mental illness, but they are not targeted to those individuals.

Mr. CRAMER. I guess it is the lack of reference or mentioning even raises for me the question of the seriousness of the commitment to this particular issue, which is not a small issue, this is a very big issue, a very big concern for me. If you want to elaborate, I am willing, otherwise I yield back.

Ms. HYDE. Just a quick——

Mr. CRAMER. Sure.

Ms. HYDE [continuing]. Response. The——

Mr. MURPHY. You can respond.

Ms. HYDE. The program I told you for fiscal year 2016, the reason I was hesitating, I didn't know which justification you were talking about, CJ 15 or 14 or——

Mr. CRAMER. Yes.

Ms. HYDE [continuing]. Sixteen. The new programs that I was telling you about, specifically the crisis one, specifically mentions serious mental illness. I have that here if you would like to see it.

Mr. CRAMER. OK, very well. Yes, what I am talking about is, the SAMHSA in brief never mentions serious mental illness. And I just—again, what it raises for me, and I think a lot of us are struggling with this, is the serious level of commitment to SMI, and we hope going forward that there is a greater acknowledgement and greater evidence that this commitment is real and it is going to be dealt with in substantive ways, as opposed to what we did last year.

I yield back.

Mr. MURPHY. Thank you. Gentleman yields back.

I do want to say that it is a tradition of this committee to let witnesses complete their things. That is why I am even asking, after Members have finished their time, to give more time to do those things. And so if there was things that the witnesses do want to finish up, we will be respectful of that because we do want to hear your comments on this. The second round, let me raise something here because part of this is some of the committee's frustration with getting responses.

Ms. Hyde, so these are a few questions about what we have requested from you. In emails my staff received this morning from someone who I think is on your staff, someone named Brian Altman who—just so I understand, does Mr. Altman work for you or at least represent you when it comes to the committee? Does that name sound familiar?

Ms. HYDE. Mr. Altman is here with me today, yes.

Mr. MURPHY. OK, good. And he has been in that position, I guess, for at least this last year from what I understand. So as you may know, we wrote Mr. Altman on March 20, 2014, almost a year

ago, to ask for some very specific information, following up on a meeting that was had with several SAMHSA officials that very day. We sent our request with as much specificity as possible to the department, and specifically to Mr. Altman, to respond. Since then, I have to say, this committee is very disappointed, we have received very little of what we have requested, despite our repeated efforts to follow up on that request. I am not sure I have a record of every communication of my office and the department on this matter, but we followed up on April 7, June 12, June 16, June 26, July 14, July 22, and September 18, and again, despite all of this, we still don't have the overwhelming majority of the information we requested, or a satisfactory explanation of why it doesn't exist.

So I was really astounded this morning to be told that my staff received an e-mail from Mr. Altman at 8:15 saying the following, "We are still reviewing the multitude of reports you have requested, and will provide the reports as soon as possible." He further writes, "We have checked with program staff and there are no documents regarding technical assistance provided to the disability rights center in Maine following the Bruce case." Now, you are familiar with the Bruce case, we spoke about this before. This is the one where the Disability Rights Center, in the medical record of the hospital it says someone advised him when asked, are you going to harm yourself, he said no, someone advised him, are you going to hurt someone else, and he said no, under the advice of someone from that agency. He then went home and shortly thereafter killed his mother. He was on medication, wasn't in treatment, et cetera, and so you can understand our concern that we have asked almost a year ago, tell us what SAMHSA is looking into this. Now, I understand part of the issue is I don't think states are required to tell you what they are doing, and I think that is important because they receive significant funding from you. So I hope you understand our committee's frustration. This is a serious case involving a homicide, and someone who was advised by an organization that you fund to stop care, despite the pleas of the family and the pleas of the treating psychiatrist to say this is a dangerous person. So please understand the seriousness of our request. We do want to make sure that you understand. You are busy, I understand, but this committee will make sure we get those records, and you will comply with that, right? I appreciate that. Thank you.

Now, with regard to this organization, Dr. Kohn, you say in your report that PAIMI—I think that is one of the things—you look at some of the evaluations done, I think you even mentioned that they are one of the ones that seems to have a report that has good accountability written in there, am I correct?

Ms. KOHN. We identified an example of an evaluation that was done that was consistent with some of the principles that GAO has talked about. We didn't evaluate that program or the quality of that evaluation, we simply cite it as an example.

Mr. MURPHY. So are you aware that the people who did that evaluation are people, several of them who are funded by SAMHSA, are part of these programs? Were you aware that—I don't know if you dug deep enough to know who these people were, but several of them appears were on the payroll or have direct funding related to this. Are you aware of that?

Ms. KOHN. We just cite it as an example. We didn't hold it up——

Mr. MURPHY. I——

Ms. KOHN [continuing]. As a——

Mr. MURPHY. I didn't think so. That is OK. I didn't think so.

Ms. KOHN [continuing]. We didn't draw any conclusions about the program.

Mr. MURPHY. But it was nonetheless listed. When you say ⅓ of the programs, I think, actually had evaluations done, and, Dr. Frank, you said that the programs within HHS have many of these evaluations, but as I look at this list, Ms. Hyde, I am looking at people who—first of all, the evaluation team, I don't see a single psychiatrist or psychologist there. I see a couple of social workers. I don't know if they practice still. I see several attorneys, but in answering the question, protection and advocacy for people with mental illness, I want to know if they are advocating for those people to get better.

This case of Mr. Bruce and other cases they have had around the country, I want to make sure that they are saying if they are in jail and they are getting abused, we are standing up for you. If they are in an institution being ignored, we are going to stand up for you. But the key should be getting care. And I look at this and I must admit this looks like the fox guarding the henhouse.

And so, Dr. Kohn, I hope you will take another look at this because I see people here that really should not be telling you whether or not a program works. Of course they are going to say it works. They get funding from it. Some of these actually are the—the person, Curtis Decker, who runs the PAIMI Trade Association. Of course he is going to say he is doing a great job. I look at other people who say they received money from SAMHSA, the projects they work on with SAMHSA. So it is a concern that I think when we see these evaluations, and an internal evaluation is no use, and particularly because—I think it was perhaps you, Ms. Hyde, or, Dr. Frank, saying it is important that outside organizations look at this. I agree wholeheartedly. That is the way we should look at this. Is the research done correctly, and bottom line, are we getting results. Not just what they are doing there, and I think under these programs too, and we were talking about prevention, I want to know if we are getting results. I wish we knew how to prevent schizophrenia. I know last summer we identified 108 genotypes of schizophrenia. I wish we could cure it but we can't cure it. We can certainly do early interventions and minimize, for a while, not awareness of it, but try and delay some of the symptoms. But we don't take of these otherwise, and so that is some advice to you.

And I recognize Ms. DeGette.

Ms. DEGETTE. Mr. Chairman, I think this is the best subcommittee in the House. This is the subcommittee where Mr. Dingell made his name, and I like to think of myself as the heir to John Dingell's legacy. And in all his years on this subcommittee, he never took the cheap shot, he never attacked witnesses personally, he never put them into traps, and I was appalled today at the—and you have been with me on this committee for 2 years. You know you have never heard me say something like this. I was appalled at the way two of the new Members of this subcommittee,

Mr. Mullin and Mr. Collins, conducted themselves today, because this is a serious and legitimate investigation. This is an investigation about the way our Federal agencies are handling serious mental illness, and to bring them in and to refuse to allow these very serious, high-level government officials to answer questions, to trap them in to a when did you stop beating your wife type of answer, it is disrespectful to the witnesses and it undermines this committee's grand tradition. So I am glad you said something about this, but, however, both of those individuals were gone by the time you did. So I hope you admonish them that is not in the grand tradition of this subcommittee.

Now, having said that, I want to follow up on their questions. The first one I want to follow up on, Administrator Hyde, is the question that Mr. Mullin was asking you about that chart. You were attempting to answer the question and he would not let you do that. So I am going to ask you, I think that Mr. Mullin raises a good point, there are a number of programs including some online things that would seem to many of us to be unrelated to what SAMHSA should be doing on serious mental health issues. You were trying to say, I think, that you were evaluating these. Can you please let us know what you are doing with these online programs, what criteria you are using, what the purpose they have, and when you are going to finish that evaluation?

Ms. HYDE. Thank you, Ms. DeGette. I was trying to say, yes, that in fact, we are trying to evaluate this. It is on our evaluation list. We are trying to take a look at it. I don't have it in front of me here today the numbers he is putting out, so I can't say if that is yes, no, or otherwise. We are looking at a number of our Web sites who have been actually held by a number of contractors, and we are bringing it inside so we can control a little bit more about what goes up on those Web sites. So we have had a very explicit approach to trying to get at the issue of are the Web sites and is the content what it should be. So we have done a fair amount of work about that, but we are in the middle of it, we are not complete, and this is one of them that is literally on the next list that we are looking at.

Ms. DEGETTE. And what is your time frame for review and completion of that?

Ms. HYDE. Actually, I just got the ability to get that scheduled, so I know it is scheduled for next week but I don't have a specific time——

Ms. DEGETTE. So it is going to be soon.

Ms. HYDE. With me. It is personally being scheduled with me——

Ms. DEGETTE. Now, some of these things that this committee has, frankly, been quite critical of that you are reviewing, those have been around for quite some number of years, is that correct?

Ms. HYDE. That is correct, and sometimes what appears on its face to be a coloring book or a song, sometimes there is actually science behind the use of those for young children, for message and for outcomes. I don't have the answer here today in front of me whether this one fits that mold or not.

Ms. DEGETTE. Well, perhaps——

Ms. HYDE. I wouldn't write it off——

Ms. DEGETTE. Yes.

Ms. HYDE [continuing]. On its face.

Ms. DEGETTE. So perhaps when you do finish that evaluation, you will supplement your testimony and let us know if you think that is worthwhile or not.

Ms. HYDE. I will.

Ms. DEGETTE. And the chairman also asked you, and we did ask you in the last hearing about that case where apparently it was a contractor of SAMHSA apparently told the person to stop taking their medication. Can we get the information on that to see if SAMHSA had any awareness of that, and if there are other situations like that, or how you are choosing those contractors? I think that would be helpful to this committee.

Ms. HYDE. We are working on that. I know it has taken a while. We want to be absolutely clear though, because we understand the seriousness of the question we are being asked, so to the extent that we are reviewing bunches of records, and if we see anything that looks inappropriate, we want to go back and check it even yet again to make sure that it is or is not——

Ms. DEGETTE. And so when do you think——

Ms. HYDE [continuing]. So——

Ms. DEGETTE [continuing]. You might be able to get us that information?

Ms. HYDE. It is very high on our list to do. I can't give you a specific date, but we have been working through it and we are pretty close to being able to give you an answer.

Ms. DEGETTE. Thank you very much.

Thank you, I yield back, Mr. Chairman.

Mr. MURPHY. Thank you. I do want to say, we don't mention Members' names when someone disagrees with them, but we will follow up, but please understand, a lot of this that I think is our frustration is I think sometimes it is just a gut check. Like when you were before this committee last year when I asked you about the painting, the $26,000 painting of two people sitting on a rock, and you told me that was for awareness. I think there are some times we just want to see our leaders have a gut check to say, you know what, maybe that is not a wise spending of taxpayers' money, and that I think sing-along songs with the circle, or whatever those other things are, do they really work? I think that is what we would like to hear more about. So we are looking forward to getting that information.

And now I want to recognize Mr. Griffith for 5 minutes.

Mr. GRIFFITH. Thank you very much.

And I don't think I will be quite as emotional this time as I was on the first round of questioning, but I do appreciate you all being here, and hope that you understand that even when we get a little excited and emotional about the issue, it is because we are trying to move the Government in the right direction, and there is sometimes frustration, but we are all, I think, everybody, you all included on the panel, trying to work into the right direction.

Dr. Kohn, in 2013, the GAO issued a report finding that the Office of National Drug Control Policy could better identify opportunities to increase program coordination. GAO recommended that ONDCP assess the extent of overlap and the potential for duplication across Federal programs engaged in drug abuse prevention

and treatment activities, and identify opportunities for increased coordination. It is my understanding that ONDCP concurred with this recommendation, am I correct in that?

Ms. KOHN. Yes, they did.

Mr. GRIFFITH. And did the fact that ONDCP concurred with GAO's recommendation mean that ONDCP totally agreed with GAO's analysis, such as the overlap of Federal programs, always being a negative?

Ms. KOHN. No, they identified that sometimes there are benefits to overlaps, such as reinforcing messages, that some of the goals, if the data were cut different ways, showed different——

Mr. GRIFFITH. So they didn't——

Ms. KOHN [continuing]. Results.

Mr. GRIFFITH. They didn't agree completely.

Ms. KOHN. No.

Mr. GRIFFITH. But they did, as I understand it, state that they were willing to work with the agencies administering these programs to further enhance coordination even if it meant not eliminating complete overlaps, is that correct?

Ms. KOHN. That is correct, and in our recommendation follow-up, that has been implemented.

Mr. GRIFFITH. And I guess the question then comes, and that was the lead-in, Dr. Frank, so here we have a different agency reaction to a similar report. Couldn't HHS have concurred with the GAO recommendation even while expressing differences on some of GAO's analysis, just like the ONDCP did?

Mr. FRANK. I think the issue here is—well, first of all, I understand your emotion and your commitment, and I only respect and admire it and that of the whole committee, so thank you for that. But I think the problem we had was, when you count programs and you count evaluations, and you do so selectively and you don't go in behind, so what was in the evaluation, what are we really doing with the program, what are you really doing over here in Medicaid, we feel like you haven't told the story and that is what made us uncomfortable, that we agree. Coordination is something that both Administrator Hyde and I have spent our careers working on. In fact, the way I met her was through a project to coordinate care for people with, at that time, chronic mental illness. And that was in 1986.

Mr. GRIFFITH. All right. We will get to one more point, and then I hope I have enough time to make one statement. In a talk you delivered in March of 2013, you indicated, and it is on YouTube, and at about the 28 minute mark you spoke about the dangers of mission creep where the aim of targeting particularly high-risk groups becomes diluted to reach lower-risk populations as well. And you noted at that time that the mission creep could have disastrous results. Do you think you have your guard up, do you think it is possible that SAMHSA may be subject to similar pressures to engage in mission creep, and how does this impact their ability to support individuals with the most high-risk and severe mental illnesses?

Mr. FRANK. I still believe the admonition, and I think it is a question that we have to constantly ask ourselves. Every time we make a sort of program decision, a budget decision, and a policy

decision, we have to ask ourselves are we working for the customers that are most important. And I think that is your question, and I think that we constantly have to ask ourselves that question, and we try to.

Mr. GRIFFITH. And I appreciate that, and appreciate the self-examination is always a good thing even when it is sometimes painful.

Part of your mission is to coordinate and to make sure things are efficient. Might I recommend, and maybe you are already doing this, and if so, please tell me, that you get a few street lawyers out there and it is probably not the right term, Mr. Chairman, but street clinicians, but people who are out there on the frontlines who might be able to help you figure out what is working and what isn't working, particularly on making sure that folks know what programs are available. So that would be my suggestion to you.

Mr. FRANK. Thank you for that suggestion. Just to remind ourselves, to give you an idea, a bunch of us, the deputy secretary, myself, our principal deputy, we went out on a homeless count the other night and we kind of walked the streets just because of that kind of inclination, and we try to visit programs, and I know Administrator Hyde does it all the time, and I think it is important because otherwise you forget.

Mr. GRIFFITH. Well, and sometimes it is good to have the folks that are out there day in and day out because when it is somebody new or different, and it is human nature, they are going to whip out the spick and span and make everything look a little bit better, but when you have folks who deal with it day in and day out and over the course of years, they can give you an unvarnished or an un-cleaned up, spic-and-span type view of what is happening in the real world. But thank you.

I yield back.

Mr. FRANK. Thank you.

Mr. MURPHY. Thank you.

I am going to recognize myself again for 5 minutes.

Dr. Kohn, when you reviewed the various agencies, did you see in there any review between agencies, for example, what we hear from states increasing instances of incarceration of the mentally ill, did you see that anybody is doing that investigation?

Ms. KOHN. We did not identify that.

Mr. MURPHY. Dr. Frank, or, Ms. Hyde, if you don't, just let me know, so it is kind of yes or no or we don't know. Are your agencies involved with looking at sort of a state-by-state report to the Nation, because we are hearing anecdotally, I am hearing from a lot of governors and secretaries who handle incarceration that they see increasing rates of people in state, county and local jails of people with serious mental illness. Is HHS conducting any study of this to give a report?

Mr. FRANK. I will take that one. Yes, a couple of things. My agency, ASPE, is conducting a study right now on mental illness and violence, mental illness and criminal justice, exactly because we have been hearing the same thing you are.

Mr. MURPHY. Do you know when that will be completed? Any idea? Within this year?

Mr. FRANK. Within this year.

Mr. MURPHY. Obviously, we would love to see that.

Mr. FRANK. We would be delighted to share it. Also, Administrator Hyde and I are actively involved in the Re-entry Council, which is an interagency council that is run by the Attorney General——

Mr. MURPHY. OK.

Mr. FRANK [continuing]. That focuses on re-entry, and a disproportionate share of people that have serious mental illnesses.

Mr. MURPHY. Let me raise another question here. With the Affordable Care Act, part of this is there is supposed to be parity for access. And, you know, we passed a parity bill here 6 years ago. It took 5 years, I think, for HHS to get us the regulations. I am still hearing a lot of concerns that parity is not taking place. Is HHS preparing any state-by-state evaluation of what states are doing with regard to meeting parity guidelines with the insurance companies that operate within the states? Is there anything happening with those that you know of?

Mr. FRANK. CMS and ASPE sit on that group as well, continuously work with insurance commissioners to, A, do more technical assistance, and also find out what is going on and help them resolve complaints as they come in from consumer groups.

Mr. MURPHY. OK. Another thing with this too is that with the ACA, a lot of people are finding themselves—they have a very high deductible, and I am hearing from a lot of psychiatrists, psychologists, social workers that people just aren't coming in for their appointments because they say if I have a $5,000 deductible for me, or a 10 or 12 or $13,000 deductible for my family, they are just not coming in for care. Is that something that HHS is also investigating to find out what those numbers are, and what impact that is having upon care?

Mr. FRANK. Yes. We are conducting several sets of analyses. One set of analyses we have been monitoring the trends and deductibles in private insurance broadly, and we are also looking at just the design of the benefit, both in the bronze and the silver plans within the ACA.

Mr. MURPHY. But you know what I am saying, is——

Mr. FRANK. Absolutely.

Mr. MURPHY [continuing]. It is very important. I think this committee——

Mr. FRANK. And it is very important——

Mr. MURPHY [continuing]. Would like to have that information.

Ms. Hyde, you talked about, when you talked about this, in families in serious mental health crisis, you want to engage the family. One of the problems we consistently heard also is the families said we want to be engaged but HIPAA laws keep us from doing that. We keep hearing stories of someone who has suffered because a doctor says I can't talk to you. And the families say, look, all they want to know is what medication is he on so I can follow up. When is the next appointment so I can get him there? I know in the past HHS has given us some clarification and said doctors can listen to family members, they are allowed to do that, but they can't kind of in a cold basis if someone calls over the phone and give information. I get that. We should protect that. And nor should we release all the records. But is this something that we can be addressing to

say how do we at least get that information when, in absence of that information, that person becomes gravely disabled and it is necessary for treatment, how are we going to deal with that?

Ms. HYDE. We worked with the Office for Civil Rights who actually was taking the lead on providing the clarification to practitioners about what you just said, Mr. Murphy, that practitioners can, in fact, listen and they can, in fact, get lots of information that can help them with treatment. I think there are a lot of clinicians who it is just easier to say I can't talk at all.

Mr. MURPHY. But it is that other part about——

Ms. HYDE. Part of what we are——

Mr. MURPHY [continuing]. Giving information. This is something I think we really have to address.

Ms. HYDE. Yes. Part of what we are trying to do is develop some training and some ability to help practitioners understand what they can and cannot do, and also to see how——

Mr. MURPHY. This is——

Ms. HYDE [continuing]. They can utilize existing state laws to get at the issue of when someone cannot make a decision for themselves.

Mr. MURPHY. I have a couple more questions. I will go to Ms. DeGette.

Ms. DEGETTE. I am sorry, I have already done my second round.

Mr. MURPHY. Well, I am doing a third and a fourth.

Ms. DEGETTE. I need to go, so——

Mr. MURPHY. OK.

Ms. DEGETTE [continuing]. I would suggest——

Mr. MURPHY. All right. Let me just say this. Dr. Frank, you have suggested that GAO has, to paraphrase you, missed the boat in its analysis of the coordination between Federal agencies by failing to coordinate with, among others, the Medicaid program. Now, this kind of goes into the struggle we are having at the Federal level, but let me ask you how you coordinate it on the ground, as you state. For example, I understand this morning the state of Kansas is debating removal of many mental health medications from its Medicaid program. Are you even aware that Kansas is proposing to remove these drugs? Apparently, the Federal Government pays 55 percent of the cost of that program, but here is the Kansas proposal to even remove those. Are you aware of that?

Mr. FRANK. I am not aware of that specific proposal. We have been concerned with the placement of psychiatric drugs on formularies generally, and have been examining that pretty carefully.

Mr. MURPHY. OK. What was that one other thing I wanted to ask? One other question I want to ask about the——

Mr. FRANK. Mr. Chairman.

Mr. MURPHY. Yes?

Mr. FRANK. I would never say that Dr. Kohn missed the boat. I have known her for too long——

Mr. MURPHY. OK.

Mr. FRANK [continuing]. To think that.

Mr. MURPHY. All right. Thank you. We don't want to have any aspersions about boats or sailors too.

Another thing, Dr. Frank, in your 2006 book, which we are promoting here, Better Not Well——

Mr. FRANK. Yes.

Mr. MURPHY [continuing]. One of the things you suggest is this creation of a new Federal agency or authority, it doesn't have to be a new agency, with budgetary oversight over all the programs that serve people with mental illness. Do you still think that is a good idea to give someone that authority so they can really, I guess I will use the word mojo, have to go to all these agencies and have to answer to someone and say is it working, is it not working, is it interacting well, are you meeting your targets, do you still believe that?

Mr. FRANK. Well, at the time I wrote that in 2005 the world was a somewhat different place, and that was the—you got the rationale for why we were proposing that right. What has changed since is, for example, the Congress has done a variety of legislative things to sort of force some of that on the ground. The Melville 811 Act, for example, forces housing and Medicaid to come together. And we have added so many institutions that now are coordinating better on the ground, that what I would like to do is see how that works out before adding another level of bureaucracy.

Mr. MURPHY. Well, I am not talking about adding another level of bureaucracy, I am talking about someone who really has the authority to call for these things that people have to respond to.

Mr. FRANK. Yes.

Mr. MURPHY. Because my concern is that, what we are hearing from Dr. Kohn's report is it is not being coordinated. I am pleased that some action just immediately took place, and that some of these agencies have not been meeting in 5 years, so we need someone who is singularly accountable to be that pivot point. I mean I say in my bill there should be an Assistant Secretary of Mental Health, which means someone within this agency that has that power and authority to go to DoD and VA and HUD and Education and Labor and saying we are going to sit down, we are going to hash this out, because somehow having at least 112 programs isn't working when we look at the outcome measures and all those things to say that. So——

Mr. FRANK. Yes, as you can imagine, I am sympathetic to the view, but I really do think that we have changed—the idea that we had was in service of making sure that the dollars got funneled to the right place, to the right people, at the right time. And we are trying a different way right now to do that, and I would like to see whether it is successful, because, in fact, I have also seen a lot of programs where we tried to coordinate the bureaucracies up here, nothing happened on the ground. And so I would like to—this time start at the ground and then work my way up, and then see what happens. But it is a hard problem and I am interested in seeing how our efforts work out because I really think they are serious and they are important.

Mr. MURPHY. All right. Well, I thank you for those things. I also know, Ms. DeGette, I am sure you also support the idea. We will work with getting SAMHSA those documents, and she is absolutely supportive. And that is the way we are. We want those documents we requested a year ago, and get the other responses here quickly.

I thank all of you for being here. This has been a very revealing report. Dr. Kohn, thank you so much. I do recognize a lot of work has to be done. You have heard that from Members here. And I think the best thing here is approach us with humility and honesty and saying, you know what, when we look at what has happened with mental health in America, it really is not good. From the thousands and thousands of families we hear, from the frustrations I hear from providers, from consumers, so many people saying this isn't working. We have to change this. And so let us ease up on saying everything is fine, and let us really look at how we have to change this. And if it takes legislative changes, we are going to push those, and I am going to continue to push that.

So I ask unanimous consent that the Members' written opening statements be introduced into the record. And without objection, the documents will be entered into the record.

And in conclusion, again, I thank all the witnesses and Members that participated in today's hearing. I remind Members they have 10 business days to submit questions for the record, and I ask the witnesses all agree to respond promptly to the questions.

And with that, this committee is adjourned.

[Whereupon, at 12:29 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

## PREPARED STATEMENT OF HON. FRED UPTON

Today we continue our examination of federal efforts to combat our nation's mental health crisis. This hearing is a natural outgrowth of the committee's investigation into the federal mental health system. Our work began following the heartbreaking December 2012 tragedy in Newtown, Connecticut, and we remain committed to addressing the problems that contributed to that tragedy.

Severe mental illness is, and should be, a top priority for U.S. public health spending. Unfortunately, the $130 billion a year being spent on mental health surveillance, research, prevention, and treatment activities, income support and other social services has not solved the problem. In Southwest Michigan, I've met with my local public health officials and local law enforcement and they agree that more needs to be done to grapple with these difficult issues.

Today we gather to discuss how we can better prioritize our taxpayer dollars to address the threat of untreated severe mental illness.

Thanks to the bipartisan efforts of this committee, and the nonpartisan expertise of Government Accountability Office, we now have some answers. GAO reports that there are at least two significant problems facing our federal agencies and their spending that addresses mental health. First, high-level interagency coordination for programs supporting individuals with serious mental illness is lacking, and SAMHSA, which is charged with promoting coordination on these matters across the federal government, seems largely to blame. Second, agency evaluations of programs specifically targeting individuals with serious mental illness are too few in number and often lacking in quality or completeness.

Although the Department of Defense and the Department of Veterans Affairs graciously accepted the GAO recommendation targeting their shortcomings, as identified by this report, HHS has explicitly rejected both of GAO's recommendations. GAO stands by its recommendations, and we're going to hear about those recommendations today.

We are looking for answers. In light of the seriousness of the GAO's findings, we must ask: why do HHS and SAMHSA think that there is no room for improvement in the areas identified by the nonpartisan government watchdog?

The untold suffering of the families and individuals impacted by the programs discussed in this report is simply too great, and the cost to the federal purse is too high, to allow us to continue on our present path. Lives are at stake, and we can and must do better. I thank Chairman Murphy for his dedication to this important matter that hits so close to home for millions of American families.

U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON ENERGY AND COMMERCE

February 9, 2015

TO: Members, Subcommittee on Oversight and Investigations

FROM: Committee Majority Staff

RE: Hearing on "Federal Efforts on Mental Health: Why Greater HHS Leadership is Needed"

On Wednesday, February 11, 2015, at 10:00 a.m. in 2123 Rayburn House Office Building, the Subcommittee on Oversight and Investigations will hold a hearing entitled "Federal Efforts on Mental Health: Why Greater HHS Leadership is Needed." This hearing is part of the Subcommittee's examination, ongoing since January 2013, of mental health programs and resources with the aim of ensuring that Federal dollars devoted to mental health are reaching the over 11 million American adults with serious mental illness (SMI) and helping them to obtain the most effective care. In particular, this hearing will examine the findings of a recent report of the U.S. Government Accountability Office (GAO), "Mental Health: HHS Leadership Needed to Coordinate Federal Efforts Related to Serious Mental Illness," GAO-15-113.[1]

## I. WITNESSES

- Linda T. Kohn, Ph.D., Director, Health Care, U.S. Government Accountability Office;
- Richard G. Frank, Ph.D., Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services
  *Accompanied by* Pamela S. Hyde, J.D.
  Administrator, Substance Abuse and Mental Health Services Administration

## II. BACKGROUND

In June 2013, the Committee, in a bipartisan request, asked that GAO compile information on how key Federal departments and agencies support programs for individuals with SMI and take steps to ensure their programs meet the needs of this population. Specifically, GAO was asked to identify (1) the Federal programs that support individuals with SMI; (2) the extent to which Federal agencies coordinate these programs; and (3) the extent to which Federal agencies evaluate such programs.

[1] GAO, *Mental Health: HHS Leadership Needed to Coordinate Federal Efforts Related to Serious Mental Illness*, GAO-15-113 (Washington, D.C.: December 2014).

GAO, through its survey of Federal agencies, identified 112 Federal programs that generally supported individuals with SMI in fiscal year 2013.[2] The majority of these programs addressed broad issues, such as homelessness, that can include individuals with SMI. These programs were spread across eight Federal agencies, including Department of Health and Human Services (HHS) as well as Department of Defense (DOD), Department of Education, Department of Housing and Urban Development, Department of Justice (DOJ), Department of Labor, Department of Veterans Affairs (VA), and the Social Security Administration. GAO found that only thirty of the 112 programs were identified by agencies as specifically targeting individuals with SMI and that four agencies – HHS, DOD, DOJ, and VA – reported obligating about $5.7 billion in fiscal year 2013 for these thirty programs.

HHS is charged with leading the Federal government's public health efforts related to mental health, and the Substance Abuse and Mental Health Services Administration (SAMHSA) is required by its enabling legislation, as amended, to promote coordination of programs relating to mental illness throughout the Federal government. However, GAO found that interagency coordination for Federal programs supporting individuals with SMI is lacking. What agency-level committees existed did not focus on, and took little action specific to SMI, GAO noted. While agencies reported some coordination by staff at the program level, GAO referenced its prior work demonstrating the value of interagency coordination, when it is supported by agency leadership, in minimizing the potential for duplication and overlap that can reduce the efficiency of Federal programs.[3]

GAO noted that meaningful program coordination and evaluation are particularly important in the case of Federal efforts to support SMI, given the size of the population affected and the complexity of treatment. GAO's prior work showed the significance of both performance monitoring activities and program evaluations, noting the particular importance of formal program evaluation to inform program managers about the overall design and operation of the program.[4] Here, however, GAO found that agencies completed few evaluations of the programs specifically targeting individuals with SMI. Citing the practices of SAMHSA in particular, GAO emphasized that ongoing monitoring and reporting of program accomplishments, while essential to performance management, cannot take the place of a formal program evaluation.

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[2] GAO acknowledged the difficulty agencies experienced in trying to define the scope of such programs and determining whether individuals with SMI were among those served by the various programs. As no compilation of federal programs related to mental health was publicly available at the onset of the Committee's investigation, earlier, on April 10, 2013, the Committee requested that the Office of Management and Budget (OMB) produce a comprehensive inventory of federal programs supporting mental health research, prevention, and treatment. On November 7, 2013, OMB supplied the Committee with a response, disclosing that in fiscal year 2012, $130 billion in federal funds were directed to mental health surveillance, research, prevention, and treatment activities, as well as income support and other social services for individuals with mental illness. At the time, OMB also acknowledged the difficulty associated with identifying all such programs across the federal government.

[3] *See* GAO, *Managing for Results: Key Considerations for Implementing Interagency Collaborative Mechanisms*, GAO-12-1022 (Washington, D.C.: Sept. 27, 2012).

[4] *See* GAO, *Government Efficiency and Effectiveness: Opportunities to Reduce Fragmentation, Overlap, and Duplication through Enhanced Performance Management and Oversight*, GAO-13-590T (Washington, D.C.: May 22, 2013) and GAO, *Designing Evaluations: 2012 Revision*, GAO-12-208G (Washington, D.C.: January 2012).

At the conclusion of the report, GAO offered two recommendations:

(1) the first recommendation called on the Secretary of HHS to establish a mechanism to facilitate intra- and interagency coordination, including actions that would assist with identifying the programs, resources, and potential gaps in Federal efforts to support individuals with SMI. HHS disagreed with this recommendation. It noted that funding for SAMHSA is allocated largely to specific programs by Congress, and thus, improving coordination should include coordination at the Congressional level. HHS affirmed that, in its view, existing program-level coordination was sufficient;

(2) the second recommendation directed the Secretaries of DOD, DOJ, VA, and HHS to document which of their programs targeted for individuals with SMI should be evaluated and how often such evaluations should be completed. HHS disagreed with this recommendation, unlike DOD, DOJ, and VA, which agreed with it. HHS argued that program evaluation is only one method of measurement to which, in the present report, GAO has attached undue importance.

Despite HHS's non-concurrence on both recommendations, GAO continues to believe that its recommendations are valid.

## III. ISSUES

The following issues may be examined at the hearing:

- What Federal programs support – or specifically target – individuals with SMI, and who administers them?
- What is the statutory role of HHS, or SAMHSA, in promoting coordination across the Federal government regarding SMI?
- What is the state of interagency coordination concerning Federal programs related to SMI and how is it impacting program reach and effectiveness?
- What is the state of program evaluations for Federal programs related to SMI and how, if at all, can the evaluation process be improved?
- What actions, if any, do HHS or SAMHSA plan to take to address GAO's recommendations in this report?

## IV. STAFF CONTACTS

If you have any questions regarding this hearing, please contact Sam Spector of the Committee staff at (202) 225-2927.

FRED UPTON, MICHIGAN
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED FOURTEENTH CONGRESS

Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–6115
Majority (202) 225-2927
Minority (202) 225-3641

March 9, 2015

Dr. Richard G. Frank
Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Dr. Frank:

Thank you for appearing before the Subcommittee on Oversight and Investigations on Wednesday, February 11, 2015, to testify at the hearing entitled "Federal Efforts on Mental Health: Why Greater HHS Leadership is Needed."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

Also attached are Member requests made during the hearing. The format of your responses to these requests should follow the same format as your responses to the additional questions for the record.

To facilitate the printing of the hearing record, please respond to these questions and requests with a transmittal letter by the close of business on Monday, March 23, 2015. Your responses should be mailed to Brittany Havens, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to brittany.havens@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Tim Murphy

Tim Murphy
Chairman
Subcommittee on Oversight and Investigations

cc: Diana DeGette, Ranking Member, Subcommittee on Oversight and Investigations

Attachments

**Richard G. Frank, PhD**
**Assistant Secretary for Planning and Evaluation**
**Department of Health and Human Services**

**Responses to Questions for the Record**

**House Committee on Energy and Commerce Subcommittee on Oversight and Investigations**

**"Mental Health: HHS Leadership Needed to Coordinate Federal Efforts Related to Serious Mental Illness"**
**February 11, 2015**

**The Honorable Tim Murphy**

1. **Please share with the Committee the status of the ASPE study on mental illness, violence and criminal justice referenced during the hearing and provide to us the final report when it is available.**

   **Answer:** We are in the process of developing a request for proposals to hire an independent contractor to assist us with carrying out this study. We would be happy to share the final report for this study when it is finished.

2. **Please share with the Committee whether HHS has seen evidence of high deductibles under the Affordable Care Act discouraging individuals from seeking treatment for mental illness.**

   **Answer:** It is too soon to assess the impact of the pricing structure of Marketplace plans on enrollees' behavior.

3. **The Protecting Access to Medicare Act (Public Law 113-93) creates a demo project for new Certified Community Behavioral Health Clinics. One of the requirements for these new outpatient mental health clinics is that they "improve availability of, access to, and participation in assisted outpatient mental health treatment in the State" (Section 223(d)(4)(A)).**

   **Assisted outpatient mental health treatment, or AOT, allows judges, after full due process, to require certain mentally ill individuals with a history of violence, arrest, and medically unnecessary hospitalizations, to be placed in six months of monitored treatment as a condition for living in the community. AOT reduces institutionalization and provides an off ramp before prison.**

   **Nearly every state has an AOT law, but they are not uniformly applied or constructed. Does HHS (SAMHSA and CMS) plan to ensure state applicants meet the AOT requirement under Section 223(d)(4)(A)?**

**Answer:** The Substance Abuse and Mental Health Services Administration (SAMHSA), the Centers for Medicare & Medicaid Services (CMS), and the Office of the Assistant Secretary for Planning and Evaluation (ASPE) are working collaboratively to implement this demonstration program. The Department of Health and Human Services (HHS) is implementing the program in accordance with section 223 of the Protecting Access to Medicare Act of 2014.

4. **What has HHS done, and what is it currently doing, to coordinate with states on implementation of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), and specifically what meetings have occurred and what resources have been shared with state insurance commissioners, state mental health agencies and state attorneys general (and when) to ensure that the Act is fully implemented and enforced at all levels of jurisdiction?**

   **Answer:** HHS has taken a number of steps to coordinate implementation of MHPAEA with states, including several calls organized by the National Association of Insurance Commissioners to review the provisions of the MHPAEA statute and regulations. CMS in particular regularly works with individual state regulators to address specific issues and provide technical assistance. SAMHSA has organized several meetings through its Regional Offices to bring together state regulators and state behavioral health agencies with CMS, ASPE, and SAMHSA staffs to brief state officials on MHPAEA regulations and respond to questions. The Department has worked extensively with regulators from New York, Illinois, Iowa, Ohio, West Virginia, Massachusetts, Connecticut, Colorado, and California, among others, on specific MHPAEA implementation issues. We also provide assistance to state regulators in analyzing how their state mental health parity laws intersect with MHPAEA. Finally, CMS is developing a qualified health plan tool to assist states and issuers in identifying areas for further review for MHPAEA compliance issues.

5. **What has HHS done, and what is it currently doing to ensure that physicians have access to the full range of mental health medications that they deem medically necessary to prescribe, without going through burdensome prior authorization or other utilization limits due to restrictive Medicaid state formularies? In specific, there are a number of currently pending state proposals to restrict the ability of Medicaid beneficiaries, and the doctors that treat them, from access to the full range of mental health medications available.**

   **Answer:** Timely access to mental health services and medications is often a critical step in treating individuals with mental health issues. HHS, acting through CMS, has taken several steps to strengthen coverage and access to these services and we are committed to working with the Congress to continue to improve outcomes for individuals who need mental health services.

As you know, state Medicaid programs that choose to offer prescription drug coverage as a benefit (currently all state and territory Medicaid programs) must meet certain minimum coverage and benefit requirements that are generally found in section 1927 of the Social Security Act. Among these is the requirement that once a drug manufacturer enters into a rebate agreement with the Secretary, states generally must include coverage for all of that manufacturer's drugs. States may elect to impose certain prior authorization requirements or establish preferred drug lists (PDLs), but the effect of these programs cannot be to deny coverage for medically-appropriate treatment.

In addition to the Medicaid prescription drug coverage requirements, in 2008, MHPAEA was enacted, supplementing and expanding upon the protections for mental health services that were enacted in the Mental Health Parity Act of 1996. MHPAEA included a number of financial and coverage requirements to ensure that mental health and substance use disorder treatments are no more restrictive than medical or surgical treatment. As you know, MHPAEA does not apply to all Medicaid plans, but its protections do extend to Medicaid managed care organizations (MCOs), the Children's Health Insurance Program, and Medicaid alternative benefit plans (ABPs).

On January 16, 2013, CMS sent a letter to state health officials and state Medicaid directors that provided additional guidance to states on the applicability of MHPAEA to Medicaid.[1] In addition, on April 6, 2015, CMS released a notice of proposed rulemaking on MHPAEA's application to Medicaid MCOs, ABPs, and CHIP. We are committed to working with stakeholders and states to ensure that Medicaid beneficiaries have access to the full range of mental health and addiction services benefits they are entitled to under the law and their state plan.

6. **Was ASPE specifically consulted by the Centers for Medicare and Medicaid Services (CMS) before CMS, in January 2014, proposed to eliminate Part D "protected class" status for medications used to treat serious mental illness? What interagency coordination occurred with respect to the CMS proposal since the January 2014 proposal?**

   **Answer:** HHS has an extensive internal review and consultation process that is applied to all regulatory, policy, funding, and program documents as well as correspondence. This proposal was thoroughly reviewed and discussed by all relevant HHS components.

7. **What consultation is HHS doing, and with whom, to address workforce shortages of psychiatrists, particularly in rural and underserved areas, and with minority populations?**

   **Answer:** HHS is committed to addressing workforce shortages. Components across HHS also are working to create a data capacity to improve documentation of the extent of workforce needs and address shortages.

[1] SHO #13-001, available at http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf.

SAMHSA is working with HRSA to expand the quality and availability of behavioral health care providers, including psychiatrists, with a particular focus on underserved communities through the National Health Service Corps (NHSC). Mental and behavioral health disciplines in the NHSC have increased significantly since 2008, from approximately 700 to 2,600 in FY 2014. Roughly one of every three clinicians in the NHSC provides mental or behavioral health services.

The NHSC provides scholarships and repays educational loans to over 9,200 clinicians providing care to approximately 9.7 million people who live in rural, urban, and frontier communities. Mental and behavioral programs eligible for the NHSC include health service psychologists, clinical social workers, professional counselors, marriage and family therapists, and psychiatric nurse specialists. HRSA also supports the Graduate Psychology Education program that trains psychologists to address access to behavioral health care for vulnerable and underserved populations.

As part of the President's *Now is the Time* initiative, both SAMHSA and HRSA are working together to expand the behavioral health workforce by supporting clinical training for behavioral health professionals through the Behavioral Health Workforce Education and Training (BHWET) Grant Program. In addition to the $35 million that was awarded in FY 2015 for this initiative, the FY 2016 President's Budget includes $56 million to support the clinical training of approximately 2,850 additional behavioral health professionals and approximately 2,750 additional paraprofessionals, including those in the areas of community health, outreach, social services, mental health, substance-use disorder , and youth.

Additionally, SAMHSA augments the workforce programs by providing workforce-development resources, technical assistance, grant programs, such as the Minority Fellowship Program, and subject matter expertise regarding mental and substance use disorder prevention, treatment and recovery settings and practice. SAMHSA also has increased its focus in this area through its new workforce strategic initiative described in its current strategic plan – *Leading Change 2.0: Advancing the Behavioral Health of the Nation 2015-2018*.[2]

SAMHSA supports the Minority Fellowship Program (MFP), which helps address the shortage of psychiatrists in underserved populations. The MFP awards grant funds and provide technical assistance to seven professional organizations identified by the Congress to support educational scholarships and training opportunities for MFP fellows. SAMHSA's National Network to Eliminate Disparities in Behavioral Health (NNED) provides a workforce development component that trains providers, including psychiatrists, serving racially and ethnically diverse underserved populations across the country. NNED includes a focus on tribes, and thus provides training for Tribal practitioners, particularly on reservations and in rural areas.

SAMHSA and HRSA also ensure collaboration between HRSA telehealth resource

[2] Available at http://store.samhsa.gov/shin/content//PEP14-LEADCHANGE2/PEP14-LEADCHANGE2.pdf.

centers and the National Frontier and Rural Addiction and Treatment Transfer Centers to expand access to behavioral health expertise, including psychiatrists, in rural and frontier communities.

Together, SAMHSA and HRSA provided a comprehensive review of programs that support workforce development in its January 2013 Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues. SAMHSA and HRSA have continued to expand efforts on behavioral health workforce. Expansion of some of these initiatives, along with new proposals, can be found in the President's FY 2016 Budget.[3]

8. **Did HHS have any interagency consultation with respect to the recent proposal to exclude psychiatry from Step 2 beneficiary assignment in the Medicare Shared Savings Program? Were any analyses conducted on this proposal's impact on the health of individuals with mental illness and substance use disorders or an ACO's ability to manage risk?**

   **Answer:** HHS has an extensive internal review and consultation process that is applied to all regulatory, policy, funding and program documents as well as correspondence. This proposal was thoroughly reviewed and discussed within and across all relevant HHS components.

**The Honorable Michael Burgess**

1. **HHS, in its comments on the GAO report, holds that the recommendation that it should establish a mechanism to facilitate interagency coordination "is not supported by a specific need identified by the agencies, stakeholders or individuals with SMI."**

a. **Did HHS perform an exhaustive survey of federal agencies, stakeholders, or individuals with SMI before forming this opinion?**

   **Answer:** HHS formed its opinion based on ongoing work and engagement with the relevant agencies, stakeholders, and individuals with SMI. However, HHS is strongly committed to promoting care coordination for people with serious mental illnesses. We believe more can be done at all levels to coordinate care for this vulnerable population.

   HHS is building upon and expanding intra- and inter-agency Federal coordination efforts related to individuals with SMI. In so doing, HHS is leveraging existing Federal coordination methods including the Behavioral Health Coordinating Council (BHCC) Subcommittee on SMI, the Interagency Task Force on Military and Veterans Mental Health, the National Action Alliance for Suicide Prevention, the U.S. Interagency

[3] Department of Health and Human Services FY 2016 Congressional Budget Justification for the Substance Abuse and Mental Health Services Administration, 9, available at http://www.samhsa.gov/sites/default/files/samhsa-fy2016-congressional-justification_1.pdf.

Council on Homelessness, the Re-entry Policy Council, and senior-level communication.

These efforts will occur in conjunction with the BHCC SMI Subcommittee and reflect current work of other Federal departments. HHS also will seek to engage other departments in these efforts, specifically to identify additional programmatic and policy approaches to address critical, unmet needs for this population.

**The Honorable David McKinley**

1. **Does HHS fund organizations that oppose the use of vaccines?**

   **Answer:** We do not track the views of HHS grantees. HHS requires grantees to follow the anti-lobbying rules that prohibit utilization of HHS appropriated funds for lobbying purposes as defined by the Labor, HHS, and Education Appropriations Act. The Federal Government cannot legally require organizations that seek or receive Federal funding to advocate or promote or refrain from advocating or promoting any particular position on policy or health related issues outside of the Federally-funded program.[4]

[4] See *Agency for Int'l Dev. v. Alliance for Open Soc'y Int'l*, 133 S. Ct. 2321 (2013).

FRED UPTON, MICHIGAN
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED FOURTEENTH CONGRESS

Congress of the United States
House of Representatives
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Minority (202) 225-3641

March 9, 2015

The Honorable Pamela S. Hyde
Administrator
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road
Rockville, MD 20857

Dear Ms. Hyde:

Thank you for appearing before the Subcommittee on Oversight and Investigations on Wednesday, February 11, 2015, to testify at the hearing entitled "Federal Efforts on Mental Health: Why Greater HHS Leadership is Needed."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

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Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Tim Murphy

Tim Murphy
Chairman
Subcommittee on Oversight and Investigations

cc: Diana DeGette, Ranking Member, Subcommittee on Oversight and Investigations

Attachments

**Pamela S. Hyde, J.D., Administrator,**
**Substance Abuse and Mental Health Services Administration**

**Responses to Questions for the Record**

**House Committee on Energy and Commerce Subcommittee on Oversight and Investigations**

**"Mental Health: HHS Leadership Needed to Coordinate Federal Efforts Related to Serious Mental Illness"**
**February 11, 2015**

**The Honorable Tim Murphy**

1. **In conversations with GAO, you mentioned the work of the Behavioral Health Coordinating Council (BHCC), established in 2010.**

a. **During the course of GAO's work on this report, it was announced that BHCC would establish a subcommittee devoted to addressing serious mental illness. Is this a result of the GAO's or this Committee's inquiries on serious mental illness?**

**Answer:** There were many factors that led to the development of the BHCC subcommittee on serious mental illness. Emerging research, Americans' increased access to health care coverage through the Affordable Care Act and behavioral health services through the Mental Health Parity and Addiction Equity Act, creation of specific agency programming, and the evolving health care delivery system provided opportunity for further coordination of Department of Health and Human Services (HHS) programs and services for people with serious mental illnesses. The GAO report, as well as interest from the Administration, the Congress, consumers, families, and providers, supports the ongoing work of this subcommittee.

b. **The serious mental illness subcommittee recently held its first meeting. Who was in attendance? What topics or Federal programs were discussed? What decisions were made? When will the Subcommittee meet next?**

**Answer:** On January 13, 2015, the BHCC Subcommittee on serious mental illness held its first meeting co-chaired by the Substance Abuse and Mental Health Services Administration (SAMHSA) Administrator Pam Hyde and National Institute for Mental Health (NIMH) Director Tom Insel. Members include representatives from the Administration on Community Living (ACL), the Agency for Healthcare Research and Quality (AHRQ), the Centers for Disease Control and Prevention (CDC), the Centers for Medicare & Medicaid Services (CMS), the Food and Drug Administration (FDA), the Health Resources and Services Administration (HRSA), and Offices of the HHS Secretary Staff Divisions, including the Assistant Secretary for Financial Resources, the Assistant Secretary for Health, and the Assistant Secretary for Planning and

Evaluation (ASPE). The subcommittee discussed the purpose for the subcommittee and the role of each entity to address the needs of people with serious mental illnesses. Specific focus centered on major HHS program efforts, such as SAMHSA's Mental Health Block Grant and *Now Is The Time* (NITT) initiatives, the NIMH Recovery After an Initial Schizophrenia Episode (RAISE) early intervention program, CMS' health home and Medicaid programs, and others. The members determined they would consult with their leadership and identify the top priorities for the subcommittee to focus on and continue to identify major program activities that target persons with serious mental illness or may serve such individuals. The second meeting will be held on March 18, 2015, and will include participants from the same HHS components. At the meeting, members of the Subcommittee will discuss initial priority areas.

c. **Will the Subcommittee coordinate programs across Federal agencies, or only at HHS?**

**Answer:** The subcommittee will focus on coordination across HHS; it also will seek to build or expand collaborations with other Federal Departments, including the Departments of Education, Housing and Urban Development, Labor, and Veterans' Affairs, and the Office of National Drug Control Policy.

2. **The Protecting Access to Medicare Act (Public Law 113-93) creates a demo project for new Certified Community Behavioral Health Clinics. One of the requirements for these new outpatient mental health clinics is that they "improve availability of, access to, and participation in assisted outpatient mental health treatment in the State" (Section 223(d)(4)(A)).**

**Assisted outpatient mental health treatment, or AOT, allows judges, after full due process, to require certain mentally ill individuals with a history of violence, arrest, and medically unnecessary hospitalizations, to be placed in six months of monitored treatment as a condition for living in the community. AOT reduces institutionalization and provides an off ramp before prison.**

**Nearly every state has an AOT law, but they are not uniformly applied or constructed. Does HHS (SAMHSA and CMS) plan to ensure state applicants meet the AOT requirement under Section 223(d)(4)(A)?**

**Answer:** SAMHSA, CMS, and ASPE are working collaboratively to implement this demonstration program. HHS is implementing the program in accordance with section 223 of the Protecting Access to Medicare Act of 2014.

3. **Was SAMHSA specifically consulted by the Centers for Medicare and Medicaid Services (CMS) before CMS, in January 2014, proposed to eliminate Part D "protected class" status for medications used to treat serious mental illness? What interagency coordination occurred with respect to the CMS proposal since the January 2014 proposal?**

**Answer:** HHS has an extensive internal review and consultation process that is applied to all regulatory, policy, funding and program documents as well as correspondence. This proposal was thoroughly reviewed and discussed within and across all relevant HHS components.

Additionally, SAMHSA worked closely with CMS during the public-comment phase of this process to facilitate a forum with the CMS Principal Deputy Administrator and Director of the Center for Medicare, which was also attended by the Administrator of SAMHSA. This forum provided an open exchange regarding the challenges and opportunities associated with the CMS proposed regulation in order for CMS to make a fully informed decision.

4. **In what ways is SAMHSA addressing or planning to address the psychiatric workforce shortage of psychiatrists, particularly in rural and underserved areas, and with minority populations, and how is SAMHSA coordinating with other Federal agencies to address this issue?**

**Answer:** SAMHSA is committed to addressing workforce shortages. Components across HHS also are working to create a data capacity to improve documentation of the extent of workforce needs and address shortages.

SAMHSA has increased its focus in this area through its new workforce strategic initiative described in its current strategic plan – *Leading Change 2.0: Advancing the Behavioral Health of the Nation 2015-2018*.[1] This initiative will support active strategies to increase the supply of trained and culturally-aware preventionists, behavioral-health and primary-care practitioners, paraprofessionals, and peers to address the behavioral health needs of the Nation. It will also improve the behavioral health knowledge and skills of those health care workers not considered behavioral health specialists.

SAMHSA-funded programs complement programs operated by HRSA, which is HHS's lead Agency for workforce development. SAMHSA supports the Minority Fellowship Program (MFP), which helps address the shortage of psychiatrists and other behavioral health practitioners in underserved populations. The MFP awards grant funds and provides technical assistance to seven professional organizations identified by the Congress to support educational scholarships and training opportunities for MFP fellows. SAMHSA's National Network to Eliminate Disparities in Behavioral Health (NNED) provides a workforce development component that trains practitioners, including psychiatrists, serving racially and ethnically diverse underserved populations across the country. NNED includes a focus on tribes, and thus provides training for Tribal practitioners, particularly on reservations and in rural areas. Among other training components, SAMHSA's NNED supports the dissemination of an array of effective strategies and promising practices such as telepsychiatry, which helps individuals in rural parts of the country access services.

[1] Available at http://store.samhsa.gov/product/Leading-Change-2-0-Advancing-the-Behavioral-Health-of-the-Nation-2015-2018/PEP14-LEADCHANGE2.

SAMHSA also works closely with other agencies within HHS on a number of workforce initiatives. SAMHSA is working with HRSA to expand the quality and availability of behavioral health care providers, including psychiatrists, with a particular focus on underserved communities, through the National Health Service Corps (NHSC). SAMHSA and HRSA also ensure collaboration between HRSA telehealth resource centers and the National Frontier and Rural Addiction and Treatment Transfer Centers to expand access to behavioral health expertise, including psychiatrists, in rural and frontier communities. Additionally, SAMHSA works with CMS to identify payment issues affecting behavioral-health professionals and services.

Together, SAMHSA and HRSA provided a comprehensive review of programs that support workforce development in its January 2013 *Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues*.[2] SAMHSA and HRSA have continued to expand efforts on behavioral health workforce. For example, SAMHS and HRSA will begin in FY 2015 to develop a consistent data set to define and track the behavioral health workforce, a capacity which currently does not exist. To implement this funding, SAMHSA has worked closely with existing Federal, state, and professional associations data collection efforts to inventory existing and emerging workforce issues, efforts and impacts, and develop a coordinated strategy.

5. **Was SAMHSA consulted with respect to the recent CMS proposal to exclude psychiatry from Step 2 beneficiary assignment in the Medicare Shared Savings Program? Were any analyses conducted on this proposal's impact on the health of individuals with mental illness and substance use disorders or an ACO's ability to manage risk?**

   **Answer:** HHS has an extensive internal review and consultation process that is applied to all regulatory, policy, funding and program documents as well as correspondence. This proposal was thoroughly reviewed and discussed within and across all relevant HHS components.

**The Honorable Marsha Blackburn**

1. **How much SAMHSA funding is making it to the state level and how much money is being kept here in Washington? Please provide a breakdown of the budget to the Committee with the amount and destination of the funds.**

   **Answer:** Of SAMHSA's total mental health budget, 96.8 percent was distributed to support states and local communities in the form of grants and contracts. Approximately 3.2 percent of the FY 2014 appropriation for activities relating to mental health went to

[2] Available at http://store.samhsa.gov/product/Report-to-Congress-on-the-Nation-s-Substance-Abuse-and-Mental-Health-Workforce-Issues/PEP13-RTC-BHWORK.

support administrative costs for SAMHSA.[3]

**The Honorable David McKinley**

1. **Does SAMHSA support organizations that favor the legalization of marijuana, or the use of marijuana to treat anxiety?**

   **Answer:** We do not track the views of HHS/SAMHSA grantees. SAMHSA requires grantees to follow the anti-lobbying rules that prohibit utilization of HHS appropriated funds for lobbying purposes as defined by the Labor, HHS, and Education Appropriations Act. The Federal Government cannot legally require organizations that seek or receive Federal funding to advocate or promote or refrain from advocating or promoting any particular position on policy or health related issues outside of the Federally-funded program.[4]

2. **Does SAMHSA believe there is a link between marijuana use and increased risk of schizophrenia?**

   **Answer:** SAMHSA support states and communities in addressing the illicit use of marijuana by youth and young adults. SAMHSA recognizes that there have been reports of an association between marijuana use and an increased risk of schizophrenia and will continue to monitor and review the science in this area, particularly around the impact of marijuana use on young people and on those experiencing or at risk of experiencing other mental health conditions.

**The Honorable Morgan Griffith**

1. **In your view, are communities, including lawyers, sufficiently aware of SAMHSA's national role in suicide prevention?**

   **Answer:** SAMHSA has been at the forefront of suicide prevention efforts, including: the provision of resources to states and organizations to engage in suicide prevention, leading interdepartmental coordination, and supporting the development and dissemination of evidence-based approaches to addressing the issue of suicide across our nation's communities. For example, SAMHSA is America's primary Federal funder of state suicide prevention initiatives through the provision of Garrett Lee Smith Youth Suicide Prevention grants to all 50 states, 47 tribes, and 175 college campuses. Through these grants, as of June 2014, over 745,000 people have been trained to identify the warning signs of suicide and to know what actions to take in response.

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[3] Funding and number of grants and contracts can be found in the SAMHSA FY 2016 Justification of Estimates for Appropriation Committees, pp. 112-147.3

[4] See *Agency for Int'l Dev. v. Alliance for Open Soc'y Int'l*, 133 S. Ct. 2321 (2013).

Examples of other SAMHSA investments in this area include:

- Assisting HHS and Department of Defense (DOD) to launch, and helping to fund, the National Action Alliance for Suicide Prevention (Action Alliance) – a public/private partnership to reduce suicide in America, which engages multiple Federal Departments (DOD, Education, VA, the Departments of Justice (DOJ) and Interior), several HHS Operating Divisions (NIH, CDC, HRSA, the Indian Health Service (IHS), and SAMHSA), and private partners across multiple sectors.[5] The Action Alliance shepherded the revision to and release of the Surgeon General's National Strategy for Suicide Prevention in September 2012, which now guides implementation of many Federal and private-sector suicide-prevention efforts. In February 2014, the Research Prioritization Task Force of the Action Alliance, co-led by NIMH, released a prioritized research agenda which outlines the research areas that show the most promise in helping to reduce the rates of suicide attempts and deaths in the next 5-10 years. SAMHSA has also worked with the Action Alliance to advance the National Strategy for Suicide Prevention. With the Action Alliance, SAMHSA supports the Zero Suicide initiative which currently includes six states and sixty health care organizations participating in a collaborative funded by SAMHSA and facilitated by the National Council for Community Behavioral Health.
- Collaboration with VA and DOD in the use of SAMHSA's National Suicide Prevention Lifeline as a major delivery system for calls to the Veterans Crisis Line/Military Crisis Line. In 2014, over 1.3 million calls were answered by the National Suicide Prevention Lifeline, including 464,500 answered calls from Veterans and other callers who followed a prompt to access the Veterans/Military Crisis Line.
- Collaboration with DOJ in the development of a set of comprehensive suicide prevention resources to support professionals who work with youth in the juvenile justice system.
- Collaboration with IHS on response to suicide and suicide clusters in Indian Country.
- Collaboration with NIMH on research prioritization, emergency department interventions, inpatient care and its alternatives, and the relationship between suicide and early/first episode psychosis.
- Launch of a new *Suicide Safe* application (app) for practitioners working with potentially suicidal patients. The app can be used by practitioners in private practice settings or in public or publicly-supported programs, such as VA facilities, IHS programs, and Federally-Qualified Health Centers.[6]
- SAMHSA promotes awareness of these programs and resources through its website, e-blasts, traditional and social media, technical assistance, and other public awareness initiatives.

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[5] Additional information available at http://actionallianceforsuicideprevention.org/.
[6] The app is available at http://store.samhsa.gov/product/SAMHSA-Suicide-Safe-Mobile-App/PEP15-SAFEAPP1.

**The Honorable Chris Collins**

1. **Over the last two years, which programs has SAMHSA recommended be terminated or have actually been terminated? Who is performing these evaluations, including, for example, of the "Building Blocks" sing-a-long, and how long will they take?**

   **Answer:** Several factors are considered when SAMHSA evaluates the effectiveness of programs: independent evaluation; opportunities to leverage resources from other SAMHSA or HHS programming; potential redirection of funds to meet emerging public health issues; and funding requirements to support existing grantees.

   On an ongoing basis, SAMHSA considers program investment across its portfolio to ensure that the services and programs offered are meeting the current needs of individuals and helping to reduce the impact of substance use disorders and mental illness on America's communities. Thus, SAMHSA ensures that it supports prevention, treatment, and recovery support services. SAMHSA has also undertaken and continues to support the systematic collection of data to assess its investments in discretionary and block grant programs. SAMHSA is expanding its efforts to improve the quality of information on behavioral health investments by providing uniform standards for evaluation, supporting rigorous evaluation designs, and producing timely results for decision makers for all evaluations of SAMHSA programs, irrespective of whether the evaluations are conducted internally, through ASPE or through third-party evaluation contractors.

   As indicated in the hearing, the *Building Blocks for a Healthy Future* website is in the process of being reviewed, among others, as part of a review and consolidation of all SAMHSA-supported websites. The goal is to reduce costs, improve functionality, and update content to increase access for the public and the health care field to critical information about mental and substance use disorders, prevention, treatment and recovery, as well as SAMHSA data, materials, and grant programs. Since the inception of this initiative, SAMHSA has conducted evaluations to assess the reach of the products. These evaluations indicate the website is highly useful for educators and parents.[7] SAMHSA's recent review, with input from the National Institute on Drug Abuse (NIDA), indicates that some of the material on the website needs to be updated. As a consequence, the website has been brought down while the updates are made. Until it is revised and brought back online, viewers accessing the website will be directed on how to find other information on early childhood development, children's mental health, and why early childhood is important to substance abuse prevention from SAMHSA and other HHS operating divisions.

[7] The content of this website is based on evidence-based research summarized in NIDA's Preventing Drug Use among Children and Adolescents: A Research-Based Guide. (2d ed. October 2013), available at http://www.drugabuse.gov/publications/preventing-drug-abuse-among-children-adolescents/acknowledgments.

2. **Please provide the Committee with a list of SAMHSA's evidence-based practices.**

**Answer:** SAMHSA continues to promote the availability and utilization of research-driven and practice-tested, evidence-based practices to improve health and social outcomes for individuals with mental and/or substance use disorders.

SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP)[8] is a decision-support tool for states and communities that is a searchable, online registry of mental health and substance abuse interventions that have been reviewed and rated by independent reviewers. Taken together, the 340 interventions on NREPP as of December 2014 have been implemented in more than 412,000 sites, in 50 states and six U.S. territories, as well as more than 114 countries with more than 141,000,000 clients. Last year, SAMHSA began the process of revising this registry to improve the selection process and rigor of the reviews of programs and practices.

In collaboration with leading researchers and academia, SAMHSA has developed specific toolkits on evidence-based practices used to prevent and treat mental and substance use disorders. These toolkits integrate clinical expertise; expert opinion; external scientific evidence; and client, patient, and caregiver perspectives so that providers can offer high-quality services that reflect the interests, values, needs, and choices of the individuals served and their families. These toolkits focus on service improvements in supported education; treatment of depression in older adults; interventions for disruptive behavior disorders; consumer-operated services; medication treatment, evaluation, and management; permanent supportive housing; family psycho-education; illness management and recovery; supported employment; integrated treatment for co-occurring disorders; and assertive community treatment.[9]

SAMHSA also has a role in helping to develop evidence-based practices by review and oversight of its grants and by its grantees bringing practice-based evidence to the behavioral health field. NIDA, NIMH, and the National Institute on Alcohol Abuse and Alcoholism, along with academic researchers, work with SAMHSA and grantees to determine what works best in different types of localities, with different types of populations, especially where evidence about best approaches is lacking or just emerging.

[8] http://www.nrepp.samhsa.gov.
[9] These toolkits are available from SAMHSA at http://store.samhsa.gov/list/series?name=Evidence-Based-Practices-KITs.