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**Congress of the United States**  
*House of Representatives*  
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June 6, 2013

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

Dear Administrator Hyde:

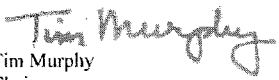
Thank you for appearing before the Subcommittee on Oversight and Investigations on Wednesday, May 22, 2013, to testify at the hearing entitled "Examining SAMHSA's Role in Delivering Services to the Severely Mentally Ill."

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.

To facilitate the printing of the hearing record, please respond to these questions by the close of business on Thursday, June 20, 2013. Your responses should be e-mailed to the Legislative Clerk in Word format at [brittany.havens@mail.house.gov](mailto:brittany.havens@mail.house.gov) and mailed to Brittany Havens, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515.

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

Sincerely,

  
Tim Murphy  
Chairman  
Subcommittee on Oversight and Investigations

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

Attachment

**Responses**  
**Questions for the Record**  
**House Committee on Energy and Commerce**  
**Oversight Hearing**  
**May 22, 2013**

**The Honorable Tim Murphy**

1. I appreciate your agreeing to stay for the testimony of Joe Bruce, who appeared on our second panel at the May 22 hearing. The role played by advocates from the Disability Rights Center, the designated agency for administering the Protection and Advocacy for Individuals with Mental Illness (PAIMI) program in Maine, in obtaining the premature release of Mr. Bruce's son, William, from Riverview Psychiatric Center, is very troubling to me.

- a. Aside from audits, what kind of regular oversight does SAMHSA perform over recipients of PAIMI formula grants?

**Response:** SAMHSA provides rigorous oversight of the grants it awards. Grantees must fulfill their role in regard to the stewardship of Federal funds, and as such, SAMHSA grants management and project officers work collaboratively to identify potential problems and areas where technical assistance might be necessary. This active monitoring is accomplished through review of reports and correspondence from the grantee, audit reports, site visits, and other information available to SAMHSA. As a condition of award, grantees must provide specific information to SAMHSA on the management, performance, and accountability of the SAMHSA grant they run. Reporting requirements include a Federal Financial Report on an annual basis and must be submitted to SAMHSA for each budget period as stated, either a quarterly, semi-annually, or an annual progress report. OMB Circular A-133 now requires that all grantees receiving over \$500,000 in Federal funding submit a data collection form in addition to the audit report, due by the earlier of 30 days after receiving the report or nine months after the end of the fiscal year. Quarterly financial reports that provide an overview of cash status are required by the Department of Health and Human Services (HHS) Division of Payment Management. The Federal Financial Report is the mechanism for reporting disbursements. Failure to submit reports by the specified due dates can result in fund access restrictions. Programmatically, SAMHSA project officers monitor the conduct and progress of grants, and collaborate with grantees in planning, implementation, and evaluation activities. Project officers' interactions with grantees might include answering questions about specific policies, advising grantees on programmatic issues, providing technical assistance, and requesting clarification about required documents as necessary.

- b. What mechanisms has SAMHSA put in place, if any, to enable individuals, like Mr. Bruce, with concerns about the practices of SAMHSA's state-by-state designated PAIMI organizations, to communicate these concerns to SAMHSA?

**Response:** Individuals may exercise their right to file a grievance with the Protection and Advocacy (P&A) system under the Protection and Advocacy for Individuals with Mental Illness Act (PAIMI Act) (42 U.S.C. § 10805(a)(9)) and regulations (42 CFR 51.25). Complaints that allege fiscal mismanagement, discrimination, etc. may be reported directly to SAMHSA, for review and further action. Individuals may also submit complaints to the HHS Office of the Inspector General (OIG). Likewise, individuals may also submit concerns to their governors' offices, since, by statute, the governor of each state designates, with HHS approval, the entity to which SAMHSA provides the PAIMI funds. If the issue of concern has to do with actions of the P&A entity conducted with other than SAMHSA funding, state action may be the most appropriate venue.

Anyone is welcome to express a concern to SAMHSA, and the appropriate staff person will address the concern or make a referral to the appropriate body that can do so.

**c. Does SAMHSA have criteria, or an established standard, against which to judge the appropriateness of a PAIMI grant recipient's advocacy efforts?**

**Response:** PAIMI project officers and grants management staff provide routine fiscal, programmatic, and monitoring oversight of all aspects of PAIMI formula grants within states. In this capacity, the project officer and grants management specialist monitor work to ensure that Federal PAIMI funds are being used consistent with the statutory authority and in compliance with PAIMI application requirements and annual program priorities established by the respective PAIMI Advisory Councils.

**i. What would SAMHSA do, if anything, if it had reason to question whether a PAIMI grant recipient, such as the Disability Rights Center, is in fact acting in the long-term best interests of a patient such as William Bruce?**

**Response:** SAMHSA receives allegations and complaints relating to health and safety concerns both from the OIG Hotline and directly from individuals. Upon receipt, SAMHSA's point-of-contact convenes a meeting with appropriate program officials. The most common and first response to health and safety allegations is normally to issue a letter to the grantee requiring it to specifically respond to each allegation. A follow-up conference call would be held with grantee officials to go over any related concerns. If these steps do not dispel the health and safety allegations, or if the allegations were considered severe in the first place, program officials would conduct a site visit, develop a corrective action plan (CAP) addressing the confirmed issues, and issue the CAP to the grantee with a deadline for completion. Classifying a grantee as high-risk, which involves imposing restrictions on the grantee's ability to drawdown grant funds, would not alone remedy health and safety issues, but may be utilized to encourage the grantee to implement the CAP.

**d. Do you believe that all of the activities performed by the Disability Rights Center, as set out in Mr. Bruce's testimony, were consistent with his son's best interests?**

**Response:** SAMHSA is unable to confirm that all of the activities performed by the Disability Rights Center were done as set out in Mr. Bruce's testimony. SAMHSA does not have statutory authority to intervene in individual cases to determine the best interests of each individual served by the PAIMI system. Rather, SAMHSA's role is to assure the entity designated to receive these Federal funds is complying with the requirements of the Federal funding. Concerns about these issues would be explored by SAMHSA staff. If concerns are brought to SAMHSA's attention regarding the actions of an individual attorney or advocate in an individual situation, SAMHSA would direct the individual concerned to the governor's office, to the state bar association responsible for oversight of attorneys licensed by that state, or in some cases to the state mental health authority if broader treatment or services issues are identified.

- e. **Do you believe that the Disability Rights Center may have been better advised not to advocate for Mr. and Mrs. Bruce to be completely shut out of their son's treatment at Riverview?**

**Response:** SAMHSA's Guiding Principles of Recovery include numerous mentions of the importance that family members play in the recovery process and explicitly states that "[i]ndividuals, families, and communities have strengths and resources that serve as a foundation for recovery."

- f. **Since the establishment of PAIMI in 1986, has there ever been an instance where a SAMHSA-funded PAIMI organization has engaged in advocacy for or against pending legislation either on the Federal or State level?**

**Response:** SAMHSA is not aware of any instance of a PAIMI organization using Federal funds to engage in advocacy for or against pending legislation at either the state or Federal level. Entities designated to receive these Federal funds may have other sources of funding in addition to PAIMI funding and may have additional responsibilities in addition to PAIMI responsibilities.

2. **In 1986, Congress established PAIMI to help families and individuals with psychiatric illnesses or developmental disabilities who were being abused or neglected. In its 2011 "Evaluation of the PAIMI Program, Phase III: Evaluation Report," SAMHSA states that Congress had an "expectation that PAIMIs [would] address both individual abuse and neglect cases and systemic deficiencies." This report suggests that SAMHSA can identify "more realistic performance indicators...when estimating the impact of systemic advocacy and policy work" by PAIMI grant recipients.**

- a. **Please identify the specific statutory language authorizing recipients of PAIMI grants to engage in systemic advocacy or policy work.**

**Response:** 42 U.S.C. § 10805(a)(1) authorizes P&A systems to: (1) investigate incidents of abuse and neglect of individuals with mental illness if the incidents are reported to the system or if there is probable cause to believe that the incidents occurred; (2) pursue

administrative, legal, and other appropriate remedies to ensure the protection of individuals with mental illness who are receiving care or treatment in the state; and (3) pursue administrative, legal, and other remedies on behalf of an individual with mental illness. The legislative history of the Act indicates that the Congress (S. Rep. No. 100-454, at 7 (1988)) intended that PAIMI authorize activities of protection and advocacy systems which address systemic deficiencies that could lead to abuse and neglect:

During the reauthorization hearing on the Act, several witnesses spoke of systemic conditions that negatively impact the working environment encountered by direct care workers. These adverse conditions include inadequate staffing levels and inadequate staff training ... The Committee recognizes that in some facilities efforts of even the most dedicated care staff to provide quality treatment continue to be frustrated by such systemic conditions, which can foster abuse and neglect. The Committee believes that the protection and advocacy activities authorized in this legislation will have a positive impact upon the working environment.

Consistent with congressional intent, PAIMI's implementing regulations direct protection and advocacy systems to carry out systemic advocacy, *i.e.*, "those efforts to implement changes in policies and practices of systems that impact persons with mental illness" (42 CFR 51.31(f)).

**b. Describe how SAMHSA collects and evaluates data of individual cases versus systemic cases closed under PAIMI in order to measure performance.**

**Response:** The annual Program Performance Report (PPR) mandated by the PAIMI Act (42 U.S.C. § 10805(a)(7)) includes outcome statements that describe or relate to the initial complaints of abuse, neglect, rights violations, and group (systemic) activities used on behalf of the clients served. The PPR from each P&A provides data on the number and types of individual cases of alleged abuse, neglect, and rights violations. The PPR also includes an outcome measure for each closed case that indicates if the case was resolved in the client's favor and resulted in positive change for the client in her/his environment, community, or facility. These data allow for review of the positive percentage rates for each of these three areas as well as a combined measure for longitudinal change over time for the individual PAIMI programs. The data also allow for comparison among the other P&As in the system and can be used to track improvement and to target areas that may need some corrective action.

**3. After hearing Mr. Bruce's testimony, do you plan to follow-up with the Disability Rights Center in any way about their use of SAMHSA funding under the PAIMI program going forward?**

**Response:** The SAMHSA project officer is in continual contact with this and other PAIMI grantees regarding the appropriate use of Federal funding.

4. Mr. Bruce mentioned in his testimony that when he approached the Maine legislature to press for an improved Assisted Outpatient Treatment law, he was shocked to encounter public opposition from the Disability Rights Center. What affirmative steps, if any, does SAMHSA take to ensure that its grant recipients, including recipients of formula grants under the PAIMI program, do not use any federal dollars to lobby for or against proposed legislation at the local, State, or Federal level?

**Response:** SAMHSA's Request for Applications (RFA) includes the following language:

Disclosure of Lobbying Activities – Federal law prohibits the use of appropriated funds for publicity or propaganda purposes or for the preparation, distribution, or use of the information designed to support or defeat legislation pending before the Congress or state legislatures. This includes “grass roots” lobbying, which consists of appeals to members of the public suggesting that they contact their elected representatives to indicate their support for or opposition to pending legislation or to urge those representatives to vote in a particular way. You must sign and submit this form, if applicable.

All applicants must complete the Disclosure of Lobbying Activities, if applicable. All grant applications must include a signed face page by the authorized representative which states that he/she agrees that the statements contained in the list of certifications are true, complete and accurate and agree to comply with any resulting terms if the Notice of Award.

All Notices of Award include a Standard Term and Condition that prohibits grant funds from being used for lobbying. Section 503 of the Labor, HHS, and Education Appropriations Act language is also included in all L/HHS-funded RFAs and standard terms & conditions.

In addition, SAMHSA has offered courses to staff that incorporate the prohibition on using Federal funds for lobbying. These courses include Appropriations Law for Business Operations in Government and The Legislative Process: Working with Congress.

Specific to the PAIMI program, the Fiscal Year (FY) 2013 RFA included the following PAIMI Grant Award Terms and Conditions:

- 1) That each PAIMI grantee submit a *Disclosure of Lobbying Activities* form [OMB approved 0348-0046, Standard Form LLL (rev. 7-97)].
- 2) Breach of Terms and Conditions: A State P&A system will be considered in breach of the terms and conditions of this grant award *for failure to satisfy any other requirements under the Act, CFR, or any other requisites*, e.g., compliance with SAMHSA audit, on-site monitoring and/or technical assistance recommendations within specified time frames.

A breach of the terms and conditions will require remedial action, which

may include the following SAMHSA actions: recommendation for suspension or termination of the PAIMI Program grant; conversion to a reimbursement method of payment; and/or agency retention of grant payments. [PAIMI RFA FY 2013].

- 3) Lobbying Prohibitions: No part of any appropriated funds contained in this Act may be used other than for normal and recognized executive-legislative relationships, for publicity or propaganda purposes, for the preparation, distribution, or use of any information kit, pamphlet, booklet, publication, radio, television, or video presentation designed to support or defeat legislation pending before the Congress, except in presentation to the Congress itself or any State legislature. *This includes "grass roots" lobbying, which consists of appeals to the public suggesting that they contact their elected officials to indicate their support for or opposition to pending legislation, or to urge those representatives to vote a particular way.* (Emphasis added)

No part of any appropriation made under this Act may be used to pay the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any direct lobbying activity designed to influence legislation or appropriations pending *before the Congress or any State legislature.* (Emphasis added)

PAIMI grantees are also made aware that lobbying with Federal funds is prohibited by applicable regulations (42 CFR 51.6(b)), which state that "[Federal a]llotments may not be used to support lobbying activities to influence proposed or pending Federal legislation or appropriations. This restriction does not affect the right of any P&A system, organization, or individual to petition Congress or any other government body or official using other resources."

As a reminder, on June 12, 2013, Paolo del Vecchio, Director of SAMHSA's Center for Mental Health Services (CMHS), sent a letter to each PAIMI grantee reiterating this information.

- 5. Are the majority of reviewers of SAMHSA competitive grants individuals who have specific advanced training and academic and professional credentials in the mental health fields rather than just experience, yes or no?**

**Response:** Yes, a majority of peer reviewers have advanced training and academic and professional credentials relevant to the behavioral health and other fields appropriate to the program under review. In the selection of peer reviewers, staff adheres to SAMHSA Extramural Policy Statement 11-02. This guidance outlines six key factors in the selection of an appropriate committee of reviewers, including "experts from various areas of specialization within relevant professional, technical and scientific fields."

6. **Your name is listed in the credits for a SAMHSA staff musical held December 1-3, 2010, and titled "A Place for Us." What role did you have in the planning and execution of this play?**

**Response:** The Administrator had no role in the planning and execution of the musical, which was about HIV/AIDS and substance abuse and mental health issues. At the request of the staff, the Administrator along with three other SAMHSA staff recorded a short song, which was played during the musical. The recording was done without professional help and without cost to the agency and was done on a break from work lasting only a few minutes.

7. **Is SAMHSA planning a staff musical for 2013?**

**Response:** No, SAMHSA is not planning a staff musical for 2013.

8. **On March 9, 2009, President Obama released a memorandum committing that "science and the scientific process must inform and guide decisions of my Administration on a wide range of issues, including improvement of public health." This memo instructed the Director of the Office of Science and Technology Policy to guarantee scientific integrity, noting that "the selection and retention of candidates for science and technology positions in the executive branch should be based on the candidate's knowledge, credentials, experience, and integrity."**

- a. **Are recipients of SAMHSA competitive grants, in each and every case prior to awarding of the grant, subjected to rigorous, blind peer review?**

**Response:** Yes, all competitive grant applications are subject to an identical and rigorous peer review process.

- b. **What steps does SAMHSA take to ensure that grant reviewers for a particular competitive grant do not stand to financially benefit from approval of that grant? What conflict of interest policies does SAMHSA have in place for its grant reviewers?**

**Response:** SAMHSA performs due diligence with regard to peer reviewer conflict of interest. In considering potential reviewers, SAMHSA will not allow individuals to review applications if their organization applied for that grant or if they have a general appearance of a conflict of interest, such as being a technical assistance provider to potential applicants. In addition, upon receiving assigned applications to evaluate, the first action a reviewer must take is to sign a form attesting that they do not have a conflict of interest with any of the applications under review.

- c. **Does SAMHSA require that those who evaluate grant applications for science quality and integrity hold advanced degrees in social work, psychology, and psychiatry?**



**Response:** SAMHSA grant reviewers are individuals who possess the specific knowledge and skill sets necessary to implement and therefore review for a specific program. When an RFA is published, the Review Administrator in the Division of Grant Review (DGR), a unit within SAMHSA's Office of Financial Resources, identifies three to five specific areas of expertise that are necessary. The Review Administrator then searches DGR's Peer Reviewer Database for individuals with these areas of expertise and seeks recommendations from program staff. The Review Administrator makes an initial selection of a large pool of reviewers and sends an e-mail to determine potential interest and availability to participate in the review of applications to the program. If an individual is interested, s/he must submit a Reviewer Contact Information form which updates their areas of expertise, resume or CV, and a paragraph outlining how their expertise and knowledge is relevant to the program. Once the Review Administrator collects information from all interested reviewers, they develop the Reviewer Matrix, a document that includes the specific and general expertise of all potential reviewers. This document is submitted to the Director of Grant Review for approval. Reviewers often have advanced degrees related to the mental health/prevention/treatment fields and decades of experience working in these fields with various populations in various settings. Many reviewers are affiliated with community-based organizations, universities, or state and local government public health authorities.

**9. Individuals with a serious mental illness often lack awareness of the existence of their illness. This serves as a common barrier to these individuals taking their medications or following their doctors' orders.**

**a. What would you suggest be done if the patient in question refuses his or her doctor-prescribed medication?**

**Response:** SAMHSA does not interfere in doctor/patient relationships and believes the patient's treatment team is in the best position to determine the appropriate treatment protocol. SAMHSA believes and supports the use of medications as one important approach to symptom management and to recovery. Therefore, SAMHSA has worked with physicians, other HHS operating divisions, and persons in recovery (often made possible with medications) to develop shared decision-making tools and practices as well as practice improvement toolkits (see also answers below to questions 1 and 2 from Representative Gingrey) to assist physicians and their patients work together to determine the best medication approaches for mental health conditions. Shared decision-making helps to assure understanding about the value of medications and medication compliance just as it does for other health conditions. Additionally, SAMHSA supports peer support and other approaches which often assist individuals to understand the role of medications in treatment and the importance of medication compliance. For those individuals with serious mental illness for whom medications are not effective or who do not choose to take medications (and are not legally required to do so), SAMHSA recommends assertive outreach and engagement efforts and practices that have shown promise in building relationships so that eventually individuals may be able to participate in treatment or services beneficial to them and their recovery.

- b. In such instances, do you think there is a role to be played by court-ordered outpatient treatment?

**Response:** SAMHSA supports the treatment and recovery of persons with mental illness in the least restrictive environments and at the earliest possible opportunity. Waiting until someone is so sick they must be relieved of their rights and freedoms is the most costly and least effective practice. Focusing on early intervention and prevention of mental illness and/or the disabling effects of such illnesses can save millions of dollars in incarceration costs, allow people to work and earn a living and reduce the burden on families. Lowering the threshold to forced treatment may discourage Americans from seeking treatment. Therefore, SAMHSA supports treatment options that engage individuals with mental illness or mental health conditions to understand their health condition as much as possible and choose treatment and service options that will be acceptable to them. When a person cannot be engaged and will not participate in necessary treatment and meets criteria for involuntary treatment, SAMHSA agrees that such approaches may be necessary. Involuntary treatment criteria and laws are governed by states and state legislation.

10. Prior to joining SAMHSA, and while serving as Cabinet Secretary for Human Services Department in New Mexico, you were already on the record opposing the introduction of AOT, along the lines of New York's Kendra's Law, in your state. You expressed this in a November 29, 2005 letter to the mayor of Albuquerque that you co-signed with Michelle Lujan Grisham, currently a Member of Congress from New Mexico's 1st District.

- a. Among your representations at the time were that "seeking an AOT law at this time would seriously divide our behavioral health community...Any discussion of forced treatment will create division and controversy." How do you reconcile your position with respect to New Mexico with the very favorable view of AOT expressed to then-Secretary Grisham at about the same time by the Commissioner of the New York State Office of Mental Health? For example, the Commissioner reported to your office that as a result of AOT, rates for hospitalizations, homelessness, arrests and incarcerations declined dramatically in New York.

**Response:** I expressed concern about the *timing and impact* of the proposed New Mexico legislation, as indicated in the quoted statement. The proposed law had not been discussed with New Mexico behavioral health stakeholders before it was initially introduced, including the judges that would have to implement the law.

Involuntary treatment is governed by states and state legislation. As indicated at the hearing, AOT can be an effective model when accompanied by sufficient financial resources to ensure that appropriate treatment services are available to individuals that are court-ordered to receive outpatient treatment. The AOT law in New York was in a state with one of the highest per capita spending for mental health services and in addition was accompanied by a significant increase in state funding for mental health treatment

services, and later funding was provided to do an extensive evaluation of New York's law. No such funding was included in the proposed New Mexico AOT legislation, even though New Mexico at the time had one of the lowest per capita spending rates in the country.

**11. In December 2011, SAMHSA announced a new working definition of "recovery" from mental and substance use disorders. Recovery is defined as "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."**

- a. Is "Recovery," defined as such, an appropriate course of treatment for the 11 million Americans SAMHSA counts as having a serious mental illness? Is a self-directed life possible or indeed optimal for everyone, if it means individuals will go off their doctor-prescribed medications?**

**Response:** SAMHSA does not define "Recovery" as a course of treatment but as a process and an outcome of better health, which can be accomplished through a number of clinical interventions and recovery supports, tailored to a person's individual needs. Medication is an important part of managing symptoms and hence the path to recovery for many persons with mental illness. Recovery can be viewed as a process by which an individual learns to manage his/her condition and lead a productive life and is facilitated by working with providers via medications, counseling, rehabilitative services, stress and relapse management, and other services and supports. The concept of recovery is for all individuals who are in process of improving their health care condition - including mental illnesses - at any stage of that condition. It does not negate the fact that a mental illness or an addiction can be a chronic or life-long condition. For too long, we have assumed as a society that persons with mental illness have a limited future and little to contribute. SAMHSA believes in recovery, with the key factor of hope that people can overcome their illnesses and live healthy, full and productive lives. Just as with other health conditions, medication is often a key part of that positive outcome, but it is unfortunately not effective for everyone or for every mental health condition.

SAMHSA's role is not limited to certain mental illnesses or a small number of mental health conditions. Rather, SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities. Thus, SAMHSA is concerned about all Americans, whether they are in need of prevention or whether they are facing mild, moderate, or serious and persistent mental health issues. SAMHSA does not support only one approach to treatment for persons with mental health and addiction issues. SAMHSA supports individuals with mental illness and persons with addiction receiving the best available medication as well as other treatments and services they need to help them on the path to recovery. SAMHSA also supports additional research to improve the availability of effective medications and other treatments and services for all mental health conditions.

Recovery is a process, not a treatment or an end state. Recovery is the goal of improved health and a productive life without addiction and without the disabling impacts of

mental illness and is important to anyone with a health care problem at any stage.

**12. What is the basis for SAMHSA's strong commitment to "peer mentoring" and "peer support" approaches to "Recovery"?**

**a. Is SAMHSA operating on the basis of any specific study which shows that peer support is more effective than the support of licensed mental health professionals?**

**Response:** SAMHSA is not operating from a position that peer support is more effective than the support of licensed mental health professionals. SAMHSA's inclusion of peer support as an evidence-based practice is based on the demonstrated outcomes of numerous studies.<sup>1</sup> Peer support services usually operate in conjunction with other clinical services which amplify the benefit of treatment by offering ongoing support and psychosocial rehabilitation. Many peer support services require that they be part of a treatment plan authorized by a "licensed practitioner of the healing arts" such as a psychiatrist, psychologist, or physician in order to be reimbursed by Medicaid under Centers for Medicare & Medicaid Services (CMS) rules. Peer support services are a valuable adjunct to traditional care that are known to contribute to improved outcomes in employment, education, housing stability, satisfaction, self-esteem, medication adherence and decrease the need for more costly services, such as hospitalizations.

The Department of Veterans Affairs (VA) has also recognized the value of peer supports and has a goal of hiring 800 peer support specialists representing people who are Veterans and who have successfully recovered from mental health conditions.

**b. How much money, in the form of grants – either formula (including block grants) or competitive – does SAMHSA provide on an annual basis for programs whose primary treatment model is based around peer mentoring or peer support?**

**Response:** SAMHSA does not directly fund any program operations whose primary treatment model is based around peer mentoring or peer support. SAMHSA promotes peer support services in behavioral health as effective, evidence-based practices mostly by providing technical assistance. As directed by Congress through appropriations legislation, SAMHSA funds the Consumer and Family State Network Grants (FY 2013 at \$6.1 million for approximately 44 new grants, 17 grant continuations, and a technical assistance center) that promote peer-to-peer support and family-to-family support, and the Consumer and Consumer Supporter Technical Assistance Centers (FY 2013 at \$1.9 million for five grants) that also provide information about peer support. SAMHSA also supports the Recovery Community Services Program for peers with addiction issues to prevent relapse and promote long-term recovery (FY 2013 at \$2.4 million for five grants and two supporting contracts).

<sup>1</sup> See a review of the evidence at <http://store.samhsa.gov/shin/content//SMA11-4633CD-DVD/TheEvidence-COSP.pdf>.

The President's FY 2014 Budget includes \$50 million for workforce activities to help train more than 5,000 additional professionals to work with students and young adults with mental illnesses and other behavioral health problems. The proposal includes \$35 million for a jointly-administered activity with HRSA to expand the Mental and Behavioral Health Education and Training (MBHET) Grant Program, \$10 million for SAMHSA's Peer Professionals training program, and \$5 million to expand SAMHSA's Minority Fellowship Program as described below. The Peer Professionals Workforce Development program would strengthen the behavioral workforce by increasing the number of trained peers, recovery coaches, mental health/addiction specialists, prevention specialists, and pre-Master's level addiction counselors working with an emphasis on youth ages 16-25.

**13. What is the vetting process that SAMHSA uses before a given mental health intervention qualifies for inclusion in the National Registry of Evidence-based Programs and Practices (NREPP)? What are NREPP's minimum requirements for review? Who performs these reviews? How does NREPP define "evidence-based"?**

**Response:** The National Registry of Evidence-based Programs and Practices (NREPP) is a voluntary, self-nominating system in which intervention developers elect to participate. There will always be some interventions that are not submitted to NREPP, and not all that are submitted are reviewed.

As outlined in "Announcement for the National Registry of Evidence-Based Programs and Practices: Open Submission Period for Fiscal Year 2014" (78 Fed. Reg. 33,854) for an intervention to be eligible for review, the submitter must provide written documentation that demonstrates the following minimum requirements have been met:

- 1) The intervention has produced one or more positive behavioral outcomes ( $p \leq .05$ ) in mental health or substance abuse among individuals, communities, or populations. Significant differences between groups over time must be demonstrated for each outcome.
- 2) Evidence of the positive behavioral outcome(s) has been demonstrated in at least one study using an experimental or quasi-experimental design. Experimental designs include random assignment of participants, a control or comparison group in addition to the intervention group, and pre- and post-test assessments. Quasi-experimental designs include a control or comparison group and pre-and post-test assessments but do not use random assignment. Studies with single-group, pre-test/post-test designs do not meet this requirement.
- 3) The results of these studies have been published in a peer-reviewed journal or other professional publication (*e.g.*, a book volume) or documented in a comprehensive evaluation report. Comprehensive evaluation reports must include the following sections or their equivalent: a review of the literature, theoretical framework, purpose, methodology, findings/results (with statistical analysis and p values for significant outcomes), discussion, and conclusions. Information must be included to

enable rating of the six Quality of Research criteria: (1) reliability of measures, (2) validity of measures, (3) intervention fidelity, (4) missing data and attrition, (5) potential confounding variables, and (6) appropriateness of analysis.

- 4) Implementation materials, training and support resources, and quality assurance procedures have been developed and are ready for use by the public.

The documentation demonstrating these minimum requirements must be provided at the time of submission.

Once an intervention has been accepted for review, the developer and NREPP staff work together to identify the outcomes and materials to be used in the review. A review generally takes several months to complete, from the initial scheduling of the kick-off call to the completion of an NREPP intervention summary. NREPP staff identifies the reviewers who will participate in the review.

- NREPP staff sends review packets to two pairs of reviewers. One pair of reviewers focuses on Quality of Research, while the other pair looks at Readiness for Dissemination.
- Each of the reviewers independently reviews the materials provided and calculates ratings using the predefined Quality of Research and Readiness for Dissemination review criteria.
- The reviewers submit their ratings to NREPP.
- If their ratings differ by a significant margin, NREPP staff may hold a consensus conference to discuss and resolve the differences.

With respect to Quality of Research, each reviewer independently evaluates the Quality of Research for an intervention's reported results using the following six criteria (links below are to the NREPP website which will provide additional information):

- 1) Reliability of measures<sup>2</sup>
- 2) Validity of measures<sup>3</sup>
- 3) Intervention fidelity<sup>4</sup>
- 4) Missing data and attrition<sup>5</sup>
- 5) Potential confounding variables<sup>6</sup>
- 6) Appropriateness of analysis<sup>7</sup>

Reviewers use a scale of 0.0 to 4.0, with 4.0 being the highest rating given.

With respect to criteria for rating Readiness for Dissemination, each reviewer independently

<sup>2</sup> <http://www.nrepp.samhsa.gov/ReviewQOR.aspx#ROM>.

<sup>3</sup> <http://www.nrepp.samhsa.gov/ReviewQOR.aspx#VOM>.

<sup>4</sup> <http://www.nrepp.samhsa.gov/ReviewQOR.aspx#FID>.

<sup>5</sup> <http://www.nrepp.samhsa.gov/ReviewQOR.aspx#MDA>.

<sup>6</sup> <http://www.nrepp.samhsa.gov/ReviewQOR.aspx#PCV>.

<sup>7</sup> <http://www.nrepp.samhsa.gov/ReviewQOR.aspx#ANA>.

evaluates the intervention's Readiness for Dissemination using the following three criteria (with links to the NREPP website for each):

1. Availability of implementation materials<sup>8</sup>
2. Availability of training and support resources<sup>9</sup>
3. Availability of quality assurance procedures<sup>10</sup>

Reviewers use a scale of 0.0 to 4.0, with 4.0 being the highest rating given.

All NREPP reviewers are recruited, selected, and approved by SAMHSA based on their experience and areas of expertise. The reviewer qualifications required for Quality of Research and Readiness for Dissemination differ because of the different kinds of expertise needed for these two areas. Once approved by SAMHSA, reviewers participate in at least 2 hours of training on the procedures and criteria they will use to rate interventions. Reviewers are paid for their participation in the training as well as any preparation time. Training is typically done via web conferencing. Reviewers are required to sign a Conflict of Interest disclosure statement for each intervention they review, to ensure they have no professional ties or financial or other interests in the intervention that could prevent an objective review.

SAMHSA does not assign reviewers to specific interventions. Instead, assignments are made by NREPP contract staff. Interventions are matched with reviewers having appropriate qualifications and the most relevant experience and content knowledge. The identity of reviewers assigned to reviews is kept confidential from both SAMHSA and the applicant.

Quality of Research reviewers must possess:

- A doctoral-level degree; and
- A strong background and understanding of current methods of evaluating prevention and treatment interventions.

In addition, candidates who have direct experience providing prevention and/or treatment services are preferred.

Readiness for Dissemination reviewers are selected from two categories: direct service experts (including both providers and consumers of services), or experts in the field of implementation.

For direct service experts, the minimum qualifications include:

- Previous experience evaluating prevention or treatment interventions; and
- Knowledge of mental health or substance abuse prevention or treatment content areas.

<sup>8</sup> <http://www.nrepp.samhsa.gov/ReviewRFD.aspx#Materials>.

<sup>9</sup> <http://www.nrepp.samhsa.gov/ReviewRFD.aspx#Training>.

<sup>10</sup> <http://www.nrepp.samhsa.gov/ReviewRFD.aspx#QA>.

For implementation experts, the minimum qualifications include:

- Previous experience implementing interventions, doing evaluation work in service settings, and/or conducting research across interventions; and
- Knowledge of mental health or substance abuse prevention or treatment content areas.



**The Honorable Marsha Blackburn**

1. **Please submit to the Committee your complete remarks, as delivered at the 2012 Alternatives Conference. If not transcribed, please provide the Committee with a videotape of your remarks.**

**Response:** The remarks were not transcribed or videotaped.

2. **When did SAMHSA begin sponsoring the Alternatives Conferences?**

**Response:** SAMHSA began sponsoring the conference when the Agency was formed in 1992.

3. **How much money have you spent on Alternatives Conferences in 2012, and in all prior years?**

**Response:** SAMHSA spent a total of \$165,373 FY 2012 funds for the Alternatives Conference. This cost includes grant supplement, consumer scholarships, speaker fees, and Federal travel.

SAMHSA provided the following dollar amounts via grants to facilitate the planning of the Alternatives conference in previous years. These amounts do not include the amount of consumer scholarship support which in general averages around \$30,000 each year to ensure that approximately 30 people with mental illnesses can attend the conference.

FY 2012: \$127,000

FY 2011: \$127,000

FY 2010: \$127,000

FY 2009: \$126,000

FY 2008: \$124,000

4. **How much money has SAMHSA spent on conferences in general?**

**Response:** As reported in the HHS report on FY 2012 conference spending, which is required by Office of Management and Budget Memorandum M-12-12, SAMHSA held 17 conferences over \$100,000 each between February and September 2012, for an aggregate cost of \$6,666,696.<sup>11</sup> FY 2012 was the first year that this information was collected and reported, and not all conferences and their costs were able to be included. SAMHSA expects the reporting in FY 2013 and beyond will be more complete due to the ongoing implementation of the reporting requirements of M-12-12, and now section 3003 of the

<sup>11</sup> [http://www.hhs.gov/open/recordsandreports/conference\\_spending\\_full.pdf](http://www.hhs.gov/open/recordsandreports/conference_spending_full.pdf).

Consolidated and Further Continuing Appropriations Act, 2013. Please note that the 2012 Alternatives conference was held in October 2012, and was therefore not included in the FY 2012 report.

In the first three quarters of FY 2013, SAMHSA estimates it will spend \$5 million on conferences, a 40 percent savings of \$3.5 million below the previously projected conference costs of \$8,478,132.

**5. What is the breakdown of money that you have spent on speakers you have had at these conferences and the scholarships that you have given?**

**Response:** In FY 2012, \$29,848 was paid for travel, lodging and registration for 28 consumers to attend the Alternatives Conference. The only scholarships provided by SAMHSA in FY 2012 were for the Alternatives Conference. For the 17 conferences that SAMHSA held from February to September 2012 that cost over \$100,000, \$51,743 was spent on speaker costs.

**6. How much did SAMHSA pay for the painting it commissioned of Sam English, as referenced in SAM HSA's newsletter from March/April 2011?**

**Response:** SAMHSA paid Mr. English \$8,500 for the painting.

**The Honorable Phil Gingrey**

1. **The Director of the National Institute of Mental Health, Thomas Insel, M.D., testified before this Subcommittee on March 5, 2013, "that effective treatments, which include medication adherence and evidence-based psychosocial therapy, can reduce the risk of violent behavior fifteen-fold in persons with serious mental illness." We also heard at the Hearing multiple testimonies on the importance of medication adherence and the tragic consequences that can follow when a person with a serious mental illness stops taking his or her prescribed anti-psychotic medications. Given the importance of medication adherence, please provide a report on what materials and information, for patients, families and treatment professionals, SAMHSA has created and disseminated, that address the importance of medication adherence for serious mental illness.**

**Response:** SAMHSA has 11 Evidence-Based Practices (EBP) Knowledge Informing Transformation (KIT) products which address various aspects of providing behavioral health evaluation and treatment for children, adults with serious mental illness and older adults. All SAMHSA's EBP KITs support adherence to medication regimes along with patient-centered treatment approaches. Implicit in this approach is for psychiatrists or other physicians who prescribe medications for patients with mental or substance use disorders to work with the patient to determine the best type and schedule of medication which will enable the person to function at the highest level. The KITs describe various types of psychosocial treatment modalities in detail which complement medication management.

The Medication, Treatment, Evaluation, and Management (MedTEAM) EBP KIT<sup>12</sup> is a specific KIT for psychiatrists and other prescribing physicians that provide guidance on EBP's related to medication management for clients/consumers with mental disorders. MedTEAM offers agencies, and the systems in which they participate, guidance on developing a systematic approach to medication management. The approach includes developing a plan to keep up with the evidence about medications, including using treatment guidelines or algorithms to inform medication decisions.

The Illness Management and Recovery EBP KIT<sup>13</sup> promotes using medications more consistently. The KIT provides practical handouts and class session descriptions which include training on how to use medications as prescribed by the psychiatrist.

Other EBP KITs in the series are:

- Family Psychoeducation;
- Integrated Treatment for Co-Occurring Disorders;
- Assertive Community Treatment;
- Intervention for Disruptive Behavior Disorders;

<sup>12</sup> <http://store.samhsa.gov/product/MedTEAM-Medication-Treatment-Evaluation-and-Management-Evidence-Based-Practices-EBP-KIT/SMA10-4549>

<sup>13</sup> <http://store.samhsa.gov/product/Illness-Management-and-Recovery-Evidence-Based-Practices-EBP-KIT/SMA09-4463>

- Consumer Operated Services;
- Permanent Supportive Housing;
- Evidence-Based Treatment for Depression in Older Adults; and
- Supported Employment;
- Supported Education: A Promising Practice.<sup>14</sup>

2. **In our own effort to find materials that SAMHSA has produced and made available to the public and professionals on the topic of anti-psychotic medications, we were able to find only two publications<sup>15</sup> <sup>16</sup>Of these two publications, neither of them made mention of the medications that are specifically formulated to address the problem of non-adherence—that is, long-acting injectable antipsychotic medications. Since long-acting antipsychotic medications have been available for more than 10 years, and provide a reliable way of certifying that patients with serious mental illness are receiving their medication, what plans does SAMHSA have for helping the public and professionals learn about these antipsychotic medications?**

**Response:** As described above, the MedTEAM EBP Kit equips treatment teams at mental health agencies with a systematic plan to ensure they use the latest scientific evidence coupled with patient input in making medication management decisions for people with mental illnesses. The KIT recognizes that the key to a client's adherence to medication therapy is their active participation and involvement in shared decision making. When clients understand and participate in their treatment regimen, they are more likely to adhere to the plan and take medication as prescribed.

SAMHSA has created an interactive decision aid on the use of antipsychotic medications that helps providers and patients choose which antipsychotic medications work best for the individual. Although the decision aid does not specifically mention long-acting injectable delivery systems for antipsychotic medications, the intent of the decision aid is for the provider and patient to review what works best when taking antipsychotic medications and how they are delivered would be a component of that conversation. The decision aid also helps them consider services and a variety of wellness activities as part of an overall recovery plan. Also available are a series of one-page, downloadable tools that include worksheets, a medication side effect checklist, questions to ask about recommended medications, and conversation starters. A companion workbook titled, *Supporting Choice: Helping Someone Make an Important Decision*, is designed to help a supporter guide a person through the process of making decisions about antipsychotic medications.

<sup>14</sup> See <http://store.samhsa.gov/list/series?name=Evidence-Based-Practices-KITs>.

<sup>15</sup> Substance Abuse and Mental Health Services Administration. *Interventions for Disruptive Behavior Disorders: Medication Management*. HHS Pub. No. SMA-11-4634, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2011.

<sup>16</sup> Substance Abuse and Mental Health Services Administration. *Shared Decision Making in Mental Health Decision Aid Considering the Role of Antipsychotic Medications in your Recovery Plan*. April 2012.

The following list is a sample of publications distributed by SAMHSA that discuss the use of antipsychotic medications in the treatment of behavioral health conditions:

- Community Conversations About Mental Health: Information Brief;<sup>17</sup>
- Illness Management and Recovery: Practitioner Guides and Handouts;<sup>18</sup>
- Integrated Treatment for Co-Occurring Disorders: Training Frontline Staff;<sup>19</sup>
- Interventions for Disruptive Behavior Disorders: Medication Management;<sup>20</sup>
- Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs In-service Training;<sup>21</sup>
- MedTEAM: Training Frontline Staff;<sup>22</sup>
- Substance Abuse Treatment for Persons With Co-Occurring Disorders;<sup>23</sup>
- SAMHSA's Wellness Initiative: Information for General Health Care Providers;<sup>24</sup> and
- What is Right for Me? Considering the Role of Antipsychotic Medications in My Recovery Plan.<sup>25</sup>

3. When an individual suffers from both schizophrenia and alcohol dependence, research has shown that they are at much greater risk for violent behavior. Over one-third of patients with schizophrenia also have a drinking problem, and the prevalence of alcohol dependence among individuals with schizophrenia is several times greater compared to the general population. Even without the added challenges of serious mental illness, alcohol dependence is strongly associated with violence and crime. In an analysis conducted by the Department of Justice, a third of all criminal offenses were alcohol-related and nearly 40% of all violent offenses were alcohol-related. As with antipsychotic medications, the problem of non-adherence is a major issue for alcohol dependent individuals. The negative impact of non-adherence on the orally-dosed alcohol dependence treatment medications is notorious and extensively well-documented in general (also see: oral naltrexone, acamprosate and disulfiram), and is correlated with increased healthcare costs. Quite simply, medications do not work if they are not taken. Given the role that excessive alcohol use plays in violent crime, and crime in general, as well as its impact on people with serious mental illness and on health, please describe what initiatives SAMHSA is funding to encourage the use of FDA-approved medications in the treatment of alcohol dependence and whether and how the issue of non-adherence with these medications is being addressed.

**Response:** SAMHSA has produced and disseminated a Treatment Improvement Protocol (TIP), "Incorporating Alcohol Pharmacotherapies into Medical Practice,"<sup>26</sup> along

<sup>17</sup> <http://store.samhsa.gov/shin/content/SMA13-4763/SMA13-4763.pdf>.

<sup>18</sup> <http://store.samhsa.gov/shin/content/SMA09-4463/PractitionerGuidesandHandouts.pdf>

<sup>19</sup> <http://store.samhsa.gov/shin/content/SMA08-4367/TrainingFrontlineStaff-ITC.pdf>

<sup>20</sup> <http://store.samhsa.gov/shin/content/SMA11-4634CD-DVD/MedicationManagementChild-IDBD.pdf>

<sup>21</sup> <http://store.samhsa.gov/shin/content/SMA09-4341/SMA09-4341.pdf>

<sup>22</sup> <http://store.samhsa.gov/shin/content/SMA10-4549/TrainingFrontlineStaff-MT.pdf>

<sup>23</sup> <http://www.ncbi.nlm.nih.gov/books/NBK64197/pdf/TOC.pdf>

<sup>24</sup> <http://store.samhsa.gov/shin/content/SMA12-4566/SMA12-4566.pdf>

<sup>25</sup> [http://162.99.3.211/sdm/DA\\_files/index.html](http://162.99.3.211/sdm/DA_files/index.html)

<sup>26</sup> <http://162.99.3.213/products/manuals/tips/pdf/TIP49.pdf>.

with a series of related publications.<sup>27</sup> The TIP covers each of the FDA-approved medications for treating alcohol use disorders and addresses pretreatment indicators, including risk factors for poor medication adherence. SAMHSA has also released a Substance Abuse Treatment Advisory, "Naltrexone for Extended-Release Injectable Suspension for Treatment of Alcohol Dependence."<sup>28</sup>

Research evidence supports that pharmacotherapy combined with psychotherapy is more effective than deploying either intervention alone. SAMHSA's NREPP features one such intervention for alcohol treatment. Broad Spectrum Treatment (BST) and Naltrexone for Alcohol Dependence is a three-to-six-month program that uses manual-guided cognitive behavioral therapy in combination with naltrexone pharmacotherapy (50mg daily) to treat adults with alcohol dependence. BST therapists deliver eight to 14 individual sessions incorporating components of motivational enhancement therapy community reinforcement, and 12-step approaches

SAMHSA's Addiction Technology and Transfer Centers communicate considerable information to the field about alcoholism and the medications used to combat this problem. They conduct training and provide resources regarding medication management and adherence, including a training PowerPoint on medication management and adherence.<sup>29</sup>

4. In your testimony before us on May 22, 2013 you stated that much of SAMHSA's funding goes to the block grants, which are passed on to States to fund substance abuse treatment - which is well over \$1 billion. We understand that a significant portion of addicted individuals relapse to drug use. Further, we understand that, for the treatment of opioid dependence, SAMHSA dedicates a great deal of funding, time and effort on the development and delivery of education and training activities with respect to substitution, or replacement therapies – medicines which can be diverted, traded, sold, smuggled and/or abused. Is it within the authority of SAMHSA to provide stronger guidance to States to use some percent of their block grant funds on FDA-approved non-addictive medications?

**Response:** The authorizing statute for the Substance Abuse Prevention and Treatment Block Grant (SABG) does not provide SAMHSA the authority to direct states to dedicate a percentage of their SABG funds to the use of specific types of medications. However, states have the flexibility to implement evidence-based practices that meet the needs of their respective jurisdictions and the use of interventions such as naltrexone combined with psychotherapy to treat opioid dependence have been highlighted in SAMHSA's consultations with state authorities as promising practices. As indicated above, SAMHSA also provides guidance through the Addiction Technology and Transfer Centers,

<sup>27</sup> See Quick Guide for Physicians Based on TIP 49 at <http://store.samhsa.gov/shin/content/SMA10-4543/SMA10-4543.pdf>; Quick Guide for Counselors Based on TIP 49 at <http://store.samhsa.gov/shin/content/SMA10-4542/SMA10-4542.pdf>; and KAP Keys for Clinicians Based on TIP 49 at <http://store.samhsa.gov/shin/content/SMA10-4544/SMA10-4544.pdf>.

<sup>28</sup> <http://162.99.3.213/products/manuals/pdfs/naltrexone.pdf>.

<sup>29</sup> See <http://www.attcnetwork.org/find/news/attcnnews/epubs/addmsg/august2012article.asp> and [http://www.attcnetwork.org/learn/topics/alcoholism/treatment\\_medications.asp](http://www.attcnetwork.org/learn/topics/alcoholism/treatment_medications.asp).

publications, and training activities.

5. **Since the inception of the Medicaid program in 1965, inpatient psychiatric services provided in an IMD (Institution for Mental Disease) have been excluded from federal matching funds. This policy has been maintained over time in order to prevent federal Medicaid funds from financing long-term state psychiatric hospitals. However, in many States, this Medicaid IMD exclusion still serves as a huge barrier to the availability of acute inpatient treatment. In many communities across Georgia and the nation, the acute inpatient psychiatric bed capacity has reached dangerously low levels, creating a genuine access crisis for emergency mental health services.**
  - a. **Has SAMHSA compiled any data on the lack of acute inpatient bed capacity and its consequences in terms of the burden placed on hospital emergency rooms, law enforcement and homeless services that you can share with the Subcommittee?**

**Response:** SAMHSA routinely reports the number of state psychiatric hospital beds available in its publication series *Mental Health, United States*. For more than 25 years, the *Mental Health, United States* series has presented nationwide measures of mental health. Published biannually by SAMHSA, the volume serves as the Nation's most comprehensive resource for mental health statistics. The data provide timely insights into the population's mental health status, the provision of mental health treatment, and funding for that treatment in the United States.<sup>30</sup>

In addition, *Mental Health, United States, 2010* (Table 46) reported that the number of mental health organizations with 24-hour hospital/residential treatment settings (including all types of organizations) decreased from 3,039 in 1986 to 2,891 in 2004. The number of beds per 100,000 civilian population in these organizations went from 111.7 in 1986 to 71.2 in 2004.<sup>31</sup>

SAMHSA reported in *Mental Health United States 2010* (Tables 113, 114, and 115) that in 2007 there were 232,636 psychiatric beds in state and local hospitals, beds in other state and local hospitals, private psychiatric hospital beds, and in all General Hospital psychiatric beds.

In addition to the number of psychiatric hospital beds, SAMHSA has highlighted approaches to comprehensive crisis services in order to help prevent the need for emergency room visits and/or psychiatric inpatient services. These include: the development of crisis service delivery system guide to establish services or expand on existing services and make them more effective; support and knowledge dissemination of effective crisis respite services to alleviate pressure on emergency rooms; and suicide response crisis services.

<sup>30</sup> <http://www.samhsa.gov/data/2k12/MHUS2010/MHUS-2010.pdf>.

<sup>31</sup> <http://www.samhsa.gov/data/2k12/MHUS2010/MHUS-2010.pdf>.

In addition, SAMHSA is aware of the CMS demonstration project that is testing whether Medicaid programs can support higher quality care at a lower total cost by reimbursing private psychiatric hospitals for certain services for which Medicaid reimbursement has historically been available. The demonstration project was authorized by section 2707 of the Affordable Care Act. The demonstration provides states with Federal Medicaid matching funds to reimburse private psychiatric hospitals for emergency inpatient psychiatric care provided to Medicaid recipients aged 21 to 64 who are experiencing a psychiatric emergency.



**The Honorable Morgan Griffith**

- 1. What is the total amount of money that SAMHSA has spent on tobacco programs annually over the last five fiscal years? How does this compare with the total funding for mental health programs, including treatment, during that same time period?**

**Response:** SAMHSA has spent the following on tobacco programs over the last five fiscal years:

FY 2008:	\$36 million
FY 2009:	\$37 million
FY 2010:	\$38 million
FY 2011:	\$38 million
FY 2012:	\$38 million

In comparison, SAMHSA has spent the following on mental health programs in CMHS over the last five fiscal years:

FY 2008:	\$911 million
FY 2009:	\$969 million
FY 2010:	\$1,019 million
FY 2011:	\$1,022 million
FY 2012:	\$994 million

**The Honorable Renee Elmers**

1. **Is SAMHSA providing funding to organizations that support and promote taking away medical treatment for the mentally ill?**

**Response:** None of SAMHSA's grants, cooperative agreements or contracts is for the purpose of supporting or promoting the denial of medical or other treatment for individuals with mental illness. SAMHSA only provides funding to organizations for the specific purposes of its grant, cooperative agreement and contract specifications, regardless of the views of the organization. Thus, no organizations are allowed to use SAMHSA funding for the purpose of supporting or promoting the denial of medical or other treatment for individuals with mental illness.

2. **What criteria do organizations have to meet before you would give them a grant, if they are supporting a treatment that is not something you would maintain is beneficial for treating mental illness?**

**Response:** SAMHSA does not give grants for treatments or services that are not beneficial for treating mental illness or substance use disorders. However, most grantees have state or Federal grants or other non-governmental resources in addition to the funds provided by SAMHSA. In general, SAMHSA grants may be awarded to domestic public or private, non-profit or for-profit organizations. Some funds are designated by the Congress for certain entities (e.g., states and territories, governor-designated entities such as PAIMI programs, or non-profits only in some cases). For example, 67 percent of SAMHSA grants are formula grants provided directly to States under SAMHSA's authorizing legislation. Other than these state formula grants, eligible organizations may include state, local, and tribal governments; institutions of higher education; other non-profit organizations (including faith-based, community-based, and tribal organizations); and hospitals. Eligibility for a particular funding opportunity announcement is specified in the Grants.gov FIND synopsis, with more detailed eligibility information found in the funding opportunity announcement. On the basis of a statute, regulation or a limitation, with appropriate justification, described in a funding opportunity announcement, SAMHSA may limit eligibility to, or exclude from eligibility, classes or types of entities. Examples are limitations on the participation of foreign entities, and programs under which only small businesses are eligible applicants.

An example of linking formulary grant eligibility or acceptance criteria to outcomes can be found in the Community Mental Health Services Block Grant (MHBG). This key source of funding for community-based services for adults with serious mental illness and children with serious emotional disturbance is used by states, territories and one tribe (hereinafter, states) to provide a range of mental health services and system infrastructure and capacity support described in their Block Grant application plans. Prior to grant award, states must demonstrate capacity and ability to report on performance and outcome data. SAMHSA's reporting systems collect and report state performance data on MHBG service recipients. SAMHSA provides monitoring and technical assistance to ensure successful grantee performance and improved outcomes for adults with serious mental illness and children/youth with serious emotional disturbance.

On the discretionary grant side, SAMHSA's Primary and Behavioral Health Care Integration program links discretionary grant eligibility or acceptance criteria to outcomes by requiring grantees improve the physical health status of adults with serious mental illness. Grantees must work as integrated clinical service communities to coordinate and integrate primary care services into publicly funded community mental health and other community-based behavioral health settings. Prior to grant award, applicants must demonstrate capacity and ability to report on performance and outcome data. SAMHSA's reporting systems collect and report grantee performance data on discretionary grant requirements.

**3. What are the details of the application process for organizations that want to receive grants from SAMHSA?**

**Response:** In order to maintain objectivity in the grant review process, all peer reviews for applications to programs supported by CMHS are performed by DGR. The peer review process is identical for all discretionary grant applications, regardless of the size or subject of award. Prior to submission to a peer review committee, every application is screened to ensure that basic eligibility requirements and program specific requirements as published in the RFA are met. Any applications that do not adhere to the administrative and programmatic eligibility screening requirements are screened out and not reviewed further.

SAMHSA employs a rigorous process that treats all applications in a fair and equitable manner. Once an application clears the preliminary screening it is sent forward to a peer review committee. Each application is reviewed by three external reviewers who have been chosen because their expertise and education align with those identified as required to successfully implement the specific program. In addition to expertise, a concerted effort is made to include diversity in reviewer pools, therefore factors such as gender, ethnicity, and geographic location are considered but do not outweigh expertise.

To ensure that all applications are reviewed in the same manner, peer reviewers are instructed to use the detailed assessment form created by DGR when scoring applications. The assessment form includes the detailed breakdown of all scored criteria from the specific program announcement. To ensure that reviewers are thorough and complete, reviewers must, for example, indicate the page number of the application where the response is found for each contributing factor. Reviewers must also write detailed comments for any criteria that they deem "Marginal" or "Unacceptable." Lastly, reviewers are asked to provide comments on the budget and participant protection elements of each application. While these two items are not scored, it still provides critical feedback for the applicants.

Applications are then ranked in score order. In making funding decisions, SAMHSA utilizes this order ranking to determine a fundable range. Frequently SAMHSA receives more applications than it can fund. However, staff may consider other factors such as population focus and/or geographic distribution when determining awards and these factors are specified in the funding announcement. When this occurs, the justification for skipping applications is provided in the funding plan that is submitted to the Administrator.

**The Honorable Henry A. Waxman**

- 1. Does SAMHSA use evidence-based approaches to identify how to prioritize its resources? Can you provide examples to the Committee?**

**Response:** Both SAMHSA's discretionary and formula grant portfolios place significant importance on the use of evidence-based practices. Discretionary grant RFAs routinely include application criteria in which applicants must describe selecting, implementing, evaluating, and sustaining evidence-based practices as a requirement of the grant.

Evidence-based programs form the basis of most key initiatives; a few examples include, but are not limited to, the National Children Traumatic Stress Initiative, Children's Mental Health Initiative, Homeless Prevention and Treatment for Homeless programs, Strategic Prevention Framework including the related Partnership for Success, Safe Schools/Healthy Students, and the Screening, Brief Intervention, and Referral to Treatment program. In addition, SAMHSA supports the advancement of evidence-based practices by disseminating key evidence based behavioral health resources such as TIPs, Technical Assistance Publications (TAPs), the NREPPs, and evidence-based toolkits to the mental health and substance abuse delivery system further facilitating practice improvement.

For formula grants, the MHBG application encourages state grantees to purchase evidence-based practices. This focus and subsequent reporting to SAMHSA through the performance measurement system, has contributed to more effective treatment through evidence-based practices for adults with serious mental illness and children with serious emotional disturbance. Data indicate a continual growth in both the number of children receiving evidence-based practices and the number of evidence-based practices established, and the number of adults reported to receive evidence-based practices increased.

The President's FY 2014 Budget proposes to work with states to use at least five percent of their MHBG funds to award competitive grants to implement the most effective evidence-based prevention and treatment approaches, focusing on promotion, prevention and early intervention. This new set-aside and focus would be used by states to demonstrate how both MHBG and other funding streams can be utilized in the changing funding and service delivery environment to have the most positive impact on the health and well-being of the persons and communities served through these set-aside awards.

- 2. Dr. Fuller Torrey, a witness on the second panel, stated in his testimony to the Committee that mass killings conducted by people with serious mental illness is "not a priority for them SAMHSA at all." Is this accurate? What steps is the agency taking to combat this problem?**

**Response:** This statement is not accurate. The Administration understands sometimes, particularly when untreated, mental illness can lead to suicide or a large-scale tragedy. Even for individuals with no likelihood of violence, untreated mental illnesses too often cause immense distress and can prevent people from living healthy, fulfilling lives. That's why the

President's gun-violence-reduction plan includes a new \$130 million initiative at SAMHSA to address several barriers that sometimes prevent people from accessing help. This initiative proposes to help teachers and others interacting with young people recognize signs of mental illness in students and refer them to mental health services if needed, support innovative state-based programs to improve mental health outcomes for young people ages 16-25, and train 5,000 more mental health professionals to serve students and young adults. SAMHSA looks forward to congressional support for those initiatives.

At the same time, it is important to note that behavioral health research and practice over the last 20 years reveal that most people who are violent do not have a mental disorder, and most people with a mental disorder are not violent.<sup>32</sup> Studies indicate that people with mental illnesses are more likely to be the victims of violent attacks than the general population.<sup>33</sup> In fact, demographic variables such as age, gender and socioeconomic status are more reliable predictors of violence than mental illness.<sup>34</sup> These facts are important because misconceptions about mental illness can cause discrimination and unfairly hamper the treatment and recovery of the nearly 20 percent of all adult Americans who experience a mental illness each year.

In FY 2013, approximately 29 percent (\$961.3 million) of SAMHSA's funding was appropriated to support mental health programs and activities, with the remainder directed to substance abuse programs and activities. As directed by Congress, of the SAMHSA mental health funding, most (\$915.3 million) supports prevention, treatment and recovery support programs and activities within CMHS. Approximately 48 percent (\$436.81 million) of CMHS funding is directed toward the Community Mental Health Services Block Grant, which provides services and supports for adults with serious mental illness and children with serious emotional disturbance. The balance of the CMHS budget (52 percent) provides support for a range of mental health prevention, treatment and recovery support services, also as directed by Congress. In FY 2013, approximately 81 percent of the CMHS budget will support adults with and at risk for serious mental illness and/or children with serious emotional disturbance. Within the CMHS budget over the last five years, 75-80 percent of appropriated funding has been used for mental health programs in support of adults with serious mental illness and children with serious emotional disturbance.

SAMHSA is extremely concerned about the violence perpetrated by and on persons with mental health conditions, and on the trauma that results from violent and mass casualty events, whether due to a weather related event, a man-made event, or the act of a person with mental illness or more often of persons with hate, terrorism, domestic violence, or other criminal intent. SAMHSA plays a critical role in the response to mass casualty events through its Disaster Technical Assistance Center, its Disaster Distress Helpline, its first responder training and disaster preparedness and response materials. SAMHSA also plays a

<sup>32</sup> Monahan J, Steadman H, Silver E, et al: Rethinking Risk Assessment: The MacArthur Study of Mental Disorder and Violence. New York, Oxford University Press, 2001 and Swanson, 1994.

<sup>33</sup> Appleby, L., Mortensen, P. B., Dunn, G., & Hiroeh, U. (2001). Death by homicide, suicide, and other unnatural causes in people with mental illness: a population-based study. *The Lancet*, 358, 2110-2112.

<sup>34</sup> Elbogen EB, Johnson SC. Arch Gen Psychiatry. 2009 Feb;66(2):152-61. doi: 10.1001/archgenpsychiatry.2008.537.

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

leadership role in addressing the primary violence that occurs by and against persons with mental health conditions, which are self-inflicted suicide attempts or death by suicide. In addition, SAMHSA staff members are active participants in the Nation Forum on Youth Violence Prevention.

SAMHSA also plays a critical role in helping states and communities address the impact of trauma through its National Child Traumatic Stress Initiative. SAMHSA is also working closely with the White House, with other operating divisions within HHS, and with other Federal agencies such as VA and the Departments of Education, Justice, and Defense (DOD), to identify ways to identify individuals with untreated behavioral health needs and build the capacity in communities, families and primary care settings to recognize and refer to treatment such individuals earlier in order to prevent negative outcomes for individuals and their families. The President's FY 2014 Budget proposes additional approaches in which SAMHSA will be able to reduce negative attitudes and increase mental health literacy so individuals with mental health needs and their families do not go unnoticed or become isolated without adequate treatment and support. For example, Project AWARE (Advancing Wellness and Resilience in Education) would increase awareness of mental health issues and connect young people with behavioral health issues and their families with needed services. Project AWARE State Grants (\$40 million) would build on the Safe Schools/Healthy Students State Planning and Community Pilot Program, which is intended to create safe and supportive schools and communities. The second component, Mental Health First Aid (MHFA) (\$15 million), proposes widespread dissemination of the MHFA curriculum and supports training to reach 750,000 students to identify mental illness early and refer them to treatment. In addition, the President's FY 2014 Budget includes \$25 million for a new Healthy Transitions Program, to assist 16 to 25 year-olds with mental illnesses and their families to access and navigate behavioral health treatment systems. SAMHSA looks forward to congressional support for those initiatives.

3. **Dr. Fuller Torrey posited in his written testimony that "SAMHSA spends millions of dollars supporting programs which actively oppose effective treatments; funds an annual anti-treatment national conference; is more concerned about psychiatric bed availability in Iraq than in the U.S.; produces picture books for children; commission's paintings (\$22,500); and holds an annual staff musical (\$80,000)." Are these statements accurate? Can you provide context on the allegations made by Dr. Torrey?**

**Response:** These statements are not accurate. SAMHSA does not fund programs that actively oppose effective treatment for mental illnesses. SAMHSA does not fund an annual anti-treatment national conference. SAMHSA is not more concerned about psychiatric beds in Iraq than in the United States.

Dr. Torrey has inaccurately referred to the Alternatives Conference as an anti-treatment annual conference. The purpose of the Alternatives Conference since first funded in 1985, seven years before SAMHSA's establishment, is to provide a forum for individuals with serious mental illnesses from all over the nation to meet, to exchange information and ideas, and to provide and receive technical assistance through hands-on skill-building, knowledge

development and knowledge application on topics such as effective treatments and supports (including medications, and evidence-based practices) and complementary services such as recovery supports and peer-support services reimbursed by Medicaid. SAMHSA's grant funding would not imply endorsement of an organization's policy positions in any case, but neither would SAMHSA provide funding to support any meeting or conference that is against treatment for mental or substance use disorders.

With regard to the allegations about Iraq, SAMHSA began providing technical assistance in 2004 to Iraq's Ministry of Health in its efforts to rebuild Iraq's mental health services sector. Such support included two conferences, one in 2005 and one in 2006 and two visits to various United States host sites by teams of Iraqi behavioral health professionals in 2008 and 2010. Discussions about availability of psychiatric beds in Iraq took place at the two conferences, at which SAMHSA provided input on a variety of behavioral health system issues ranging from the development of community-based services to institutional care.

SAMHSA has produced a handful of picture books for very young children because according to scientific evidence it is more effective to communicate with very young children via picture books and visuals to help them understand mental health and help them recover from traumatic experiences. Age-appropriate intervention tools explain the importance of mental health and demonstrate ways to appropriately express feelings relevant to the age group (the coloring books are a good example of how a young child can learn about mental health and emotions).

American Indian/Alaska Native (AI/AN) populations have indicated a desire for materials and information produced by AI/AN individuals and sensitive to AI/AN values and traditions. In 2010, SAMHSA engaged a Native American artist who is a person in recovery from alcoholism and depression and who has created images and posters for Native American substance abuse and other health and human services programs throughout the country. This individual, just as any graphic artist assisting with materials development, produced an original image in the form of a painting from which he printed posters including SAMHSA's phone number and website for information about behavioral health and ways to find treatment, as well as positive behavioral health messages. Mr. English also helped launch the public awareness effort at a small event at the SAMHSA building involving SAMHSA employees and representatives from the Indian Health Service as well as other HHS agencies. The posters were ultimately disseminated to tribal leaders throughout the country to post in their facilities and use in their programs and to individuals requesting the posters through SAMHSA's online store.

SAMHSA staff is comprised of dedicated, creative and passionate professionals who care deeply about the issues they work on each day. To provide information about SAMHSA's programs, services, and issues and keep staff up to date on issues in the field, staff members sometimes conduct in-service trainings for their colleagues using experts in SAMHSA or other agencies. This process helps provide information for SAMHSA staff and for interested stakeholders and individuals in the field. SAMHSA's direct costs for this production were approximately \$7,000 for set support and sound.

**Was the artwork painted by Sam English used as the basis for outreach materials? If so, how many tribes received the outreach materials on the topic of mental health? What value did these outreach materials play with regard to achieving a successful outcome for this program?**

**Response:** Yes, as outlined above, the artwork was used as the basis for outreach materials to the AI/AN community. SAMHSA has provided the posters, which include the image of an AI/AN community, ways to obtain information on behavioral health issues by listing SAMHSA's phone number and website, as well as positive behavioral health messages, to representatives of Federally-recognized tribes and tribal organizations who have requested the posters or who attended various tribal consultation events. The value added by the outreach materials is that culturally-appropriate public awareness materials were made available to reach the AI/AN population which responds best to materials and information produced by AI/AN individuals and sensitive to AIAN values and traditions. Data from SAMHSA's National Survey on Drug Use and Health show that AI/AN individuals were more likely than persons from other racial/ethnic groups to have needed treatment for alcohol or illicit drugs in the past year and that the percentage of adults aged 18 or older having serious thoughts of suicide in the past year was 13.1 percent. These data show the importance of reaching the AI/AN population in order to ensure that they receive treatment for behavioral health issues.

**4. Dr. Torrey's statement referred to the Vice President's Task Force on Gun Violence. He stated:**

**To support the SAMHSA position it invited a psychiatrist, Dr. Daniel Fisher, to testify before the Biden Task Force. SAMHSA had to invite an outside psychiatrist because it has nobody among its 574 staff who has expertise on severe mental illness.... Dr. Fisher stated categorically to the Task Force that mental illness and violence are not linked, an assertion that is contradicted by more than 20 studies. Dr. Fisher, whose organization receives \$330,000 each year from SAMHSA, is unusual in his belief that schizophrenia is not a disease of the brain, an assertion that is contradicted by literally hundreds of studies.... Rather Dr. Fisher describes the condition called schizophrenia as "severe emotional distress" or "a spiritual experience." This is apparently consistent with SAMHSA's position.**

**Please comment on the role of SAMHSA on the Vice President's Task Force, and on the accuracy of the statements above.**

**Response:** Dr. Torrey's statements related to the expertise of SAMHSA staff on the topics of adults with serious mental illness and children with serious emotional disturbance are inaccurate. Dr. H. Westley Clark, M.D., J.D., M.P.H., CAS, FASAM, is an expert in serious mental illness and has previously served as an associate clinical professor, Department of Psychiatry, University of California at San Francisco. In addition, SAMHSA's National Advisory Council includes experts in serious mental illness and serious emotional



disturbance including Dr. Stephanie Le Melle, Dr. Donald E. Rosen, and Dr. Benjamin F. Springgate.

SAMHSA of course recognizes that schizophrenia is one of many diagnoses listed in the DSM-5, and is a serious mental illness. However, SAMHSA's statutory authority and mission do not permit the agency to limit its focus to only those individuals who experience specific diagnoses in the DSM-5.

SAMHSA's role in the Vice President's Task Force on Gun Violence was to provide expertise on the issues of mental health promotion and early intervention, as well as on the state of the mental health workforce. Proposals related to reducing the impact of mental illness on America's communities were included in the President's Now is the Time plan. SAMHSA recommended potential meeting participants but did not decide which individuals or organizations from the mental health community would have an opportunity to meet with the Vice President's Task Force, but is aware that a wide range of behavioral health professionals representing psychology, social work, counseling, state mental health authorities, county behavioral health authorities, community mental health and substance abuse providers, along with advocates representing children and families who have experienced behavioral health issues, participated. No one testified for the Task Force – these mental health experts and advocates were invited to a meeting with Secretary Sebelius and other Administration officials.

- 5. Dr. Fuller Torrey asserted that SAMHSA did not collect data on people living with mental illness who receive social security benefits because agency officials "have no interest in these questions." Is this statement accurate? What barriers exist for SAMHSA to collect information on social security recipients?**

**Response:** The Social Security Administration is the Federal agency responsible for collecting data on individuals receiving Social Security Disability Insurance. The information that Dr. Torrey may be seeking can be found in the publication, Annual Statistical Report on the Social Security Disability Insurance Program, 2011, at Table 6 (Distribution, by sex and diagnostic group, December 2011).<sup>35</sup> SAMHSA uses this and other data for surveillance, program planning and policy purposes.

- 6. Dr. Sally Satel, a witness on the second panel, testified:**

**When I was on the Advisory Council from 2002 to 2006, we repeatedly were trying to have some input into the decisions regarding the grants that were approved but it was clear that we were pretty much there to rubberstamp those grants. They had already been approved. We asked repeatedly if we could see them prior to approval or if we could review them after approval and then have our assessment be reconsidered, and we were turned away**

<sup>35</sup> [http://www.ssa.gov/policy/docs/statcomps/di\\_asr/2011/sect01b.pdf](http://www.ssa.gov/policy/docs/statcomps/di_asr/2011/sect01b.pdf).

every time.

**Can you explain the role of a member of the Advisory Council? Do participants select the recipients of grants?**

**Response:** The Federal Advisory Committee Act defines an advisory committee as “any committee, board, commission, council, conference, panel, task force, or other similar group” that is “established or utilized” by the President or an agency “in the interest of obtaining advice or recommendations” for the President or one or more agencies or officers of the Federal Government.” (5 U.S.C. App. 2 § 3(2))

A member of an Advisory Council serves as a source of independent expertise and advice – not decision-making – on policy and program activities carried out by the committee. A member of an Advisory Council may make recommendations but does not make decisions on technical evaluation reports/summary statements for contract proposals, grants, and cooperative agreements. (Federal Advisory Committee Management Handbook, revised edition January 2003, Part I(E).

The function of advisory committees is advisory only, unless specifically provided by statute or Presidential directive. [41 CFR 102-3.30(e)]

Advisory committees are advisory only and do not select the recipients of grants. All SAMHSA councils and committees perform a policy and program advisory role and the three Center councils have an additional, legally required grant “second-level” review role. (SAMHSA Policy and Guidance Handbook for Advisory Committee Members, Section 2, revised May 2011)

SAMHSA’s peer review system, required by law (Section 504 of the Public Health Service Act) and known as a two-level review process, is used to ensure that knowledgeable, objective review of the technical merit and quality of grant and cooperative agreement applications is conducted before funding decisions are made by the officials in SAMHSA. Section 412 of the Health Professional Partnerships Act of 1998 (P.L. 105-392) amended section 504 of the Public Health Service Act by eliminating the requirement for council review of contracts. Thus, councils perform second-level review only for grant and cooperative agreement applications.

The two-level review system involves: (1) peer review by an Initial Review Group; and (2) second-level review by a Center national advisory council. Although all competing grant and cooperative agreement applications are subject to peer review, generally only grant and cooperative agreement applications where the direct costs exceed \$150,000 are subject to the second-level council review. The purpose of this second-level council review is primarily to assure the process used by SAMHSA to make decisions on grants using the peer review process is adhered to and is sufficient to assure objectivity, and is not intended to allow advisory council members to select grantees.

**The Honorable Paul Tonko**

1. **What proportion of SAMHSA's mental health budget in 2013 funded the Consumer and Consumer-Supporter Technical Assistance and the Centers and the Protection and Advocacy for Individuals with Mental Illness program?**

**Response:** The National Consumer and Consumer Supporter Technical Assistance Centers consists of five grantees, three of whom are Consumer Technical Assistance Centers and two are Consumer Supporter Technical Assistance Centers. Each is funded at \$330,000 annually for a subtotal of \$1,650,000. The Consumer and Consumer-Supporter Technical Assistance Centers total funding for FY 2013 is \$1,875,102 and represents 0.2 percent of the SAMHSA Mental Health appropriation of \$915 million.

The PAIMI program is 3.75 percent of SAMHSA's FY 2013 mental health budget.

2. **What important services do these two programs provide to people living with serious mental illness?**

**Response:** The Technical Assistance Centers assist in the transformation of the mental health system by promoting services for adults with serious mental illnesses. They promote skill development for individuals with mental illnesses (sometimes called consumers) with an emphasis on business and management; strengthening consumer organizations and leadership in communities; collaboration with other consumers, families, advocates, providers, and administrators; coalition building; self-management/self-help approaches to symptom and illness management; evaluation and policy formation; and building opportunities for meaningful paid employment.

Most of the requests received by the Technical Assistance Centers are for materials; referrals to self-help groups and clinical and non-clinical services; and for trainings. The Technical Assistance Centers have available 169 English-language materials and 23 English-language written training curriculums. The majority of the written training curriculums focus on Assertive Community Treatment teams, recovery, and self-help or organizational skills. The Technical Assistance Centers also have 29 written training curriculums or materials in non-English languages: 17 in Spanish, ten in Japanese, and two in French.

As mentioned in response to previous questions, the purpose of the PAIMI program is to: (1) ensure that the rights of individuals with mental illness are protected; (2) assist states to establish and operate a protection and advocacy system for individuals with mental illness, which will protect and advocate the rights of such individuals through activities to ensure the enforcement of the Constitution and Federal and state statutes; and (3) investigate incidents of abuse and neglect of individuals with mental illness if the incidents are reported to the system or if there is probable cause to believe that the incidents occurred.

3. **In contrast, what percentages of SAMHSA's mental health funding went directly to States to support mental health treatment services in 2013?**

**Response:** Over half (54.8 percent) of CMHS funding will go directly to states to support mental health treatment services for people with serious mental illness in FY 2013. Approximately 81 percent of SAMHSA's total CMHS budget for FY 2013 will support adults with and at risk for serious mental illness and/or children with serious emotional disturbance, with grants to states, communities, and other entities. Within the CMHS budget over the last five years, 75-80 percent of all appropriated funding has been used for mental health programs in support of adults with serious mental illness and children with serious emotional disturbance.

4. **What efforts has SAMHSA undertaken to specifically address the issue of mental health stigma and what type of investment do you think is necessary to truly change public opinion on this issue? Are there specific statistics or metrics used by SAMHSA to quantify the impact that mental health stigma has on the rate of untreated mental illness?**

**Response:** SAMHSA has been working on the issue of negative attitudes associated with mental illnesses since its formation in 1992. SAMHSA has invested in many grants and programs not only to help individuals with mental illnesses find the help they need, but also to change the external prejudice and discrimination associated with mental illnesses and the internal shame and embarrassment that often prevents people from seeking help. SAMHSA has done this through a multitude of programs including the What a Difference a Friend Makes Campaign; the SAMHSA Voice Awards program; the Resource Center to Promote Acceptance, Dignity, and Social Inclusion; National Children's Mental Health Awareness Day; suicide prevention awareness campaigns; and many more. Although these programs have shown to be effective based on evaluations, much more can be done to bring mental illness out of the shadows and be considered by the American public as an acceptable condition for which to seek help. SAMHSA does track survey data in SAMHSA's NSDUH that shows that negative attitudes and prejudice associated with mental illnesses are one of the top reasons individuals avoid seeking treatment and services, and also the fear of disclosing a mental illness to an employer inhibits individuals from seeking treatment. Many national surveys show that the fear of social rejection, prejudice, and discrimination has a chilling effect on help seeking. SAMHSA will continue working to educate people about the importance of behavioral health issues as public health issues; to help reduce negative attitudes, prejudice and misinformation about behavioral health, mental illness, and addictions; and to encourage individuals and families to seek services when they experience mental health and/or substance abuse conditions.

In addition, SAMHSA is participating in the coordination and planning process for the White House's National Conference on Mental Health scheduled for this summer. The purpose of the event will be to discuss how we can all work together to reduce negative attitudes and perceptions about mental illnesses, encourage people experiencing mental health problems to reach out for help, and encourage friends and family members to support their loved ones and connect them with help.

5. **Can you briefly describe the work that SAMHSA does in the area of suicide prevention and discuss what programs like the National Suicide Prevention Hotline are having on reducing the rate of suicide in the United States?**

**Response:** SAMHSA provides grants to states, tribes and colleges for youth suicide prevention, as authorized by the Garrett Lee Smith Memorial Act. Since the start of the program in 2005, 49 states, 44 tribes, one territory, and 146 college campuses have received funding for their youth suicide prevention efforts. SAMHSA also funds the National Suicide Prevention Lifeline, a network of 161 crisis centers across the United States which answers calls through the toll free number 1-800-273-TALK (8255). The Lifeline currently answers over 80,000 calls per month. SAMHSA-funded evaluations have found that approximately 25 percent of callers to the Lifeline are suicidal at the time they make the call, approximately 20,000 callers per month. The crisis centers 24/7 live trained responders provide crisis intervention, emergency rescue when needed, referral to mental health treatment providers, and other services as well as follow up for suicidal callers. The Lifeline also provides a crisis chat service, and works in collaboration with VA and DOD to route the more than 17,500 callers every month who press "1" to the Veterans Crisis Line.

SAMHSA also funds the Suicide Prevention Resource Center and participates in and helps support the National Action Alliance for Suicide Prevention, a public-private partnership co-chaired by former Senator Gordon Smith and Secretary of the Army John McHugh. Last year, the Action Alliance, working together with the Surgeon General of the United States, released a revised National Strategy for Suicide Prevention. While it is not possible to say what the rate of suicide in the United States would be without these programs, SAMHSA believes that its suicide prevention programs are saving lives. The effort has a goal of reducing the number of deaths by suicide over the next five years.