

ONE HUNDRED THIRTEENTH CONGRESS  
**Congress of the United States**  
**House of Representatives**

COMMITTEE ON ENERGY AND COMMERCE

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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

## Attachment—Additional Questions for the Record

### 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?
  - 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?
  - c. Does SAMHSA have criteria, or an established standard, against which to judge the appropriateness of a PAIMI grant recipient's advocacy efforts?
    - 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?
  - 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?
  - 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?
  - 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?
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.
  - b. Describe how SAMHSA collects and evaluates data of individual cases versus systemic cases closed under PAIMI in order to measure performance.
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?
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?
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?
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?
7. Is SAMHSA 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?
  - 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?
  - c. Does SAMHSA require that those who evaluate grant applications for science quality and integrity hold advanced degrees in social work, psychology, and psychiatry?

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?
  - b. In such instances, do you think there is a role to be played by court-ordered outpatient treatment?
  
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 1<sup>st</sup> 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.
  
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?
  
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?
  - 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?

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"?

#### **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.
2. When did SAMHSA begin sponsoring the Alternatives Conferences?
3. How much money have you spent on Alternatives Conferences in 2012, and in all prior years?
4. How much money has SAMHSA spent on conferences in general?
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?
6. How much did SAMHSA pay for the painting it commissioned of Sam English, as referenced in SAMHSA's newsletter from March/April 2011?

#### **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.
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>1,2</sup>. Of these two publications, neither of them made mention of the

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<sup>1</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. Accessed May 30, 2013 at: <http://store.samhsa.gov/shin/content/SMA11-4634CD-DVD/MedicationManagementChild-IDBD.pdf>

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?

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.
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?
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

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<sup>3</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. Accessed May 30, 2013 at: <http://store.samhsa.gov/product/Shared-Decision-Making-in-Mental-Health-Decision-Aid/SMA12-4696>

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?

### **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?

### **The Honorable Renee Ellmers**

1. Is SAMHSA providing funding to organizations that support and promote taking away medical treatment for the mentally ill?
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?
3. What are the details of the application process for organizations that want to receive grants from SAMHSA?

### **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?
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?
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?

4. 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?
5. 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.

6. 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?
7. 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 every time.

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

### **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?

2. What important services do these two programs provide to people living with serious mental illness?
3. In contrast, what percentages of SAMHSA's mental health funding went directly to States to support mental health treatment services in 2013?
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?
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?