Statement of Joseph Parks, M.D.

before the

Oversight and Investigations Subcommittee of the House Committee on Energy and Commerce

on the

"Examination of SAMHSA's Role in Delivering Services to the Severely-Mentally Ill."

May 22, 2013

“The health of the people is really the foundation upon which all their happiness and all their powers as a state depend.”

Benjamin Disraeli, British Prime Minister, 1877

A. CREDENTIALS

My name is Joseph Parks, M.D.

I want to thank Chairman Murphy and Congressman DeGette for the opportunity to testify today at this hearing on the “Examination of SAMHSA’s Role in Delivering Services to he Severely-Mentally Ill.”

I am a board certified psychiatrist and was the first psychiatrist nationally to complete a fellowship in emergency psychiatry. I've served as Medical Director for the Missouri Department of Mental Health for 20 years. For three years I was the Director of its mental health operation.

For the past three years I have also served as Director of the Missouri Institute for Mental Health (MIMH) that is part of the University of Missouri St. Louis with the academic title of Distinguished Professor of Science. For the past 12 years I have been president of the Medical Directors Council of the National Association of State Mental Health Program Directors – also known as NASMHPD.

Throughout my career I have continued to provide direct patient care and I currently see patients at a federally qualified health center in Columbia, Missouri. I have previously been medical director of state hospitals in Chicago, Illinois, in Cincinnati, Ohio, and I have provided psychiatric services to homeless mentally ill patients in shelters and through assertive community treatment teams.

I have previously been part of the faculty of Department of Psychiatry at the University of Cincinnati, University of Chicago, and University of Missouri at Columbia. I'm testifying today in my individual capacity, and not on behalf of any organization.

B. Experience with SAMHSA

Through my role with the Missouri Department of Mental Health, I have been familiar with the SAMHSA Mental Health Bock Grant (MHBG) Program. In 2013, Missouri received MHBG funding in the amount of $7,495,010. Missouri's MHBG funds have only increased by 7.7 percent over its funding level in 2010, a rate of increase far below the rate of inflation in the cost of providing services. The Substance Abuse Block Grant is far larger – $25,895,523 in 2013 – but has actually gone down by 1.3 percent since 2010.

IN 2013, Missouri will use 93 percent of its MHBG funds for purchasing mental health treatment services for uninsured persons or purchasing services that cannot be covered by Medicaid, 2 percent will be spent on suicide prevention, and nearly 5 percent will be spent on administrative costs.

SAMHSA requires that 95 percent of MHBG funds must be spent on services and only 5 percent can be spent on administrative costs.

Through my role at Missouri's Department of Mental Health, I have also been familiar with SAMHSA's discretionary grants. I have been the principal investigator for suicide prevention grants and SBIRT (brief screening assessment and intervention for excessive drinking and risky drug use) grants.

In 2013, the Missouri Department of Mental Health received $4,395,873 in funding for six different discretionary grants from the Center for Mental Health Services (CMHS) at SAMHSA, and $7,679,234 in funding for three discretionary grants from the Center for Substance Abuse and Treatment (CSAT).

The six CMHS grants include:

- Improving the organization and delivery of mental health services across communities;
- Transitioning young adults from child mental health services to adult mental health services;
- Serving homeless mentally ill persons,
- Identifying very young children at risk for mental health problems and intervening early;
- A data reporting grant; and
- A youth suicide prevention grant.

The first three grants primarily target persons with serious mental illness and account for 63 percent of the total funding. The youth suicide prevention grant emanates from funds that are Congressionally designated and are to be used for that purpose.

Through my role as Director of MIMH, I am familiar with the evaluation of SAMHSA grants. The goals of the SAMHSA grants goals usually include a required evaluation component to determine how effectively they are implemented and what the outcome and results of the interventions. MIMH is currently evaluating 14 separate SAMHSA grants totaling $4,350,095 to nine different organizations. Only one of these grants is for consumer advocacy and it amounts to less than 1 percent of the total funding.

C. Role of SAMHSA in Serving Persons with SMI

Although the amounts are modest and inadequate to meet overall needs, the SAMHSA block grant funds play an important role in funding services for uninsured persons. Most people develop serious mental illness (SMI) in their late teens or 20s before they have established employment and prior to coverage under employment-based insurance. MHBG funds have been extremely helpful in covering the mental health needs for this population.

SAMHSA discretionary grants play an important role in implementing new evidence-based practices and improving the quality of care to persons with serious mental illness. Grant programs that have been particularly successful in Missouri in improving the quality of services to persons with mental illness include Co-Occurring State Incentive Grants (COSIG), which improve the ability of both community mental health centers and substance abuse provider agencies to serve persons that have both mental illness and substance abuse conditions concurrently. Prior to these grants it would be common for a person who had both serious mental illness and addiction to be told by the community mental health center that they could not be treated for their serious mental illness until their addiction was treated. Substance abuse treatment agencies would not treat them until their serious mental illness was stable.

With the COSIG grants, there is truly a "no wrong door" approach by community mental health centers and substance abuse treatment provider agencies in welcoming the person who needs treatment and engage those individuals immediately. This is a particularly important improvement with respect to reducing violence by persons with mental illness. The presence or absence of a substance use disorder is the major predictive factor of whether or not a person with mental illness will be more violent than a person without mental illness. The SAMHSA grants for reduction of seclusion and restraint have markedly reduced episodes of violence in our state hospitals.

SAMHSA discretionary grants also fund technical assistance to states. Missouri has received technical assistance in reducing seclusion or restraint from NASMHPD that was funded by SAMHSA. The landmark study by the NASMHPD Research Institute (NRI) that found that persons in public mental health systems died 25 years younger than the general population was implemented with SAMHSA funding.

The NASMHPD study was instrumental in creating a public dialogue about the need for integration of behavioral health in general medical care, and the role that serious mental illness plays in increasing the cost of general medical care in the Medicaid and Medicare programs. SAMHSA has responded nationally to this epidemic of death among persons with SMI by funding over 90 CMHCs nationally to provide integrated behavioral health and medical care.

SAMHSA has also emphasized that a modern mental health and addiction system in the states should have prevention, treatment and recovery support services available both on a

stand-alone and integrated basis with primary care, and should be provided by appropriate organizations and in other relevant community settings. SAMHSA’s proposed continuum comprises of nine domains, including:

- Health Homes
- Prevention and Wellness Services
- Engagement Services
- Outpatient and Medication Assisted Treatment
- Community Supports and Recovery Services
- Intensive Support Services
- Other Living Supports
- Out of Home Residential Services
- Acute Intensive Services

Block grant funding has especially critical for the full range of activities and services that a comprehensive state system should include such as early identification and intervention, supported housing, crisis services, all the way to inpatient services.

Moreover, these services are not only for individuals with a mental or substance use disorder, but also support their families who are critical to achieving recovery and resiliency.

Briefly, before I turn to specific policy recommendations, I also would like to acknowledge SAMHSA's substantial support during various state and regional natural disasters over the last few years. Due to the SAMHSA’s leadership and the tools they have provided on a prospective basis, it has allowed state mental health agencies to be on the ground to lend assistance on many levels to residents devastated by recent hurricanes, tornados and flash floods in several states.

D. Recommendations for Improving Treatment of SMI and Reducing Violence

1) Increase the Resources Available through Both the SAMHSA Mental Health Block Grant and Discretionary Grants

SAMHSA resources have not kept pace with either the general rate of inflation in the cost of care or with the markedly increased demand for mental health services that has

occurred in the last 10 years. It is critically important that Congress provide SAMHSA with appropriate funding so the agency can disseminate important tools to states and communities for improving the treatment of serious mental illness, and providing the early interventions that will be the most effective means of reducing violence that involve persons with serious mental illness.

2) Develop a National Approach for Increasing Psychiatric Workforce

The demand for psychiatric services is far outstripping the ability of the available workforce to supply timely, needed care. Severe workforce gaps are increasing and significantly restricting access to essential treatment services for persons with serious mental illness.

According to a University of North Carolina (UNC) 2008 study commissioned by the Health Resources and Services Administration (HRSA), the United States has a significant shortage of mental health professionals, especially "prescribers". The current supply of psychiatrists is at least 30,000 short of what is needed.

The projected demand for all physicians continues to rise outstripping the projected increase in physicians. For psychiatry, the anticipated demand has risen dramatically. The number of people seeking psychiatric services has increased because of the growing and aging population, mental health parity and anti-stigma efforts. The number of psychiatric problems has increased because of the economic downturn and the psychological toll of two wars. Other factors increasing the demand for psychiatrists are direct marketing of psychiatric medications to the public and an increase in the number of FDA black box warnings causing primary care clinicians to be reluctant to prescribe psychotropics. This is occurring at the same time that the projected supply of psychiatrists is flat.

Psychiatrists are not increasing in number because retirements are outnumbering those entering the workforce through training. Currently 55 percent of psychiatrists are older than age 55. In a recent projection using a similar methodology to the UNC study, the deficit has increased to 45,000. Patients often have to wait months to see a psychiatrist because clinics cannot find enough psychiatrists to hire to provide service. Hospitals have closed their psychiatric units due to difficulties in recruiting psychiatrists to staff those operations. Current national shortages in mental health professionals, specifically psychiatrists, will continue to exacerbate. All projections estimate the gap between unmet need and supply will widen substantially over the next 20 years.

3) Specific Discretionary Grant Recommendations

a. **Grants Funding Mental Health First Aid** – Early identification and treatment can prevent a mental illness from developing into a disability or leading to suicide or violence against others.

Mental Health First Aid (MHFA) is a groundbreaking public education program that helps the public identify, understand, and respond to signs of mental illnesses and substance use disorders. The idea behind MHFA is no different than that of traditional first aid: to create an environment where people know how to help someone in emergency situations. But instead of learning how to give CPR or how to treat a broken bone, the 8-hour course teaches people how to recognize the signs and symptoms of mental health problems and how to provide initial aid before guiding a person toward appropriate professional help.

The interactive 8-hour course is presented by instructors who have been certified through an intensive 5-day training. The course presents an overview of mental illness and substance use disorders in the U.S. and introduces participants to risk factors and warning signs of mental health problems, builds understanding of their impact, and overviews common treatments. Those who take the course to certify as Mental Health First Aiders, learn a 5-step action plan encompassing the skills, resources and knowledge to help an individual in crisis connect with appropriate professional, peer, social, and self-help care. Since its introduction in the U.S. four years ago, more than 50,000 people have been trained in 47 states and the District of Columbia. Mental Health First Aid can create community environments more alert to, and prepared to intervene in, the psychiatric distress, that leads to suicide and violence against others.

b. **Grants to Implement and Improve the Integrated Treatment of Substance Abuse Disorders and Mental Health Disorders in Persons with SMI** - The presence of substance abuse is the strongest predictor that persons with SMI will commit violence. We can do much better addressing substance abuse disorders in people with SMI.

c. Grants Supporting Effective Early Treatment of Psychotic Illness - Our nation’s approach to helping people with psychotic illnesses like schizophrenia is shameful.

Usually, young people slip into psychotic illnesses for several years while they – or their families – get no help. When they have a “first psychotic break,” they usually are briefly hospitalized. Almost always, medications take the worst of the

symptoms away – within days or weeks. So then they are discharged with a referral to care and maybe a recommendation of a support group. This is woefully, stupidly deficient! Having symptoms reduced is not a cure. When people feel better, and especially since the drugs have significant side effects, they often stop taking the medications. Relapse is likely. Usually the second psychotic break is worse. And then the revolving door begins.

Often after decades people figure out how to manage their illness, but by then they are often on permanent disability status, unemployed, and in terrible health. Some have suggested that the solution to this problem is going backward – not forward – to the days when stays for individuals in psychiatric hospitals were measured in months and years. This is simply idiotic.

There is no research to suggest it is effective. It is terribly expensive. Hospitals cannot be run (as the old asylums were) on unpaid patient labor. And a civilized society cannot detain people on a vague hope they will get better. So we should not turn the clock back on mental health care. But we do need a modern approach to care for people with psychotic disorders, one that replaces both the asylum and the revolving door with continuous team treatment like that we provide for people with chronic medical problems. Teams delivering First Episode Psychosis (FEP) care have figured out how to do this work. It is person-centered, family driven, collaborative and recovery oriented. Staying in school or work is encouraged – though adaptations may be needed. It is time to implement this approach, as both Australia and Great Britain have done. We need not lag behind other nations in this area.

Our country needs to make modest investments now to develop FEP teams so that families anywhere in the state struggling with a young adult who is slipping away from sanity can get good care reasonably close to home. The Committee's attention to this issue could have an enormous positive effect.

4) Make HIPAA Work as it Was Originally Intended

Although HIPAA explicitly allows health care providers and providers of health care related services to share protected health information absent patient consent for the purposes of treatment, which includes care coordination, many health care providers continue to insist that they can only share protected health information with the patient's consent.

Adding additional groups with whom health care providers are allowed to share information, such as family members who are directly supporting the persons coordination of care, is unlikely to be successful when health care providers routinely interpret HIPAA as prohibiting sharing protected health information absent patient consent, even between other health care providers, when in fact that is what HIPAA explicitly allows.

These health care providers are taking an inappropriately restrictive interpretation of HIPAA in an attempt to reduce their personal and organizational liability, as opposed to taking an interpretation that maximizes the patient's best interests in receiving coordinated care. In short, their primary goal is not what is best for the patient but rather how best to limit their own liability risks. This is both clinically dangerous for patients because it results in information not being shared that would improve care decisions, and at the same time economically wasteful for the health care system in that it results in unnecessary repetition of assessments, tests, and hospitalizations.

There is a need for a national initiative to retrain health care providers to error on the side of sharing protected health information when it would benefit the individual receiving treatments. There is a need for a national strategy to make the perceived liability risk of not sharing information, when it could have been shared and the lack of sharing information results in patient harm, as great as or greater than the perceived risk of sharing information absent patient consent.

5) **Increase Federal Support for Mental Health Courts**

I have been involved in providing mandatory treatment through different modalities – including inpatient and outpatient civil commitment – guardianship, not guilty by reason of insanity processes, probate court orders and in mental health and drug courts in Ohio, Illinois, and Missouri.

All three states have outpatient commitment laws and in all three states they are difficult to implement and only used rarely. The major barrier has been the unwillingness of police and sheriff departments to commit resources to enforcing violations of commitment orders. Local law enforcement almost uniformly indicate that they do not have the resources in terms of officers available to assist with mental health treatment in this manner and that crimes the have been committed, or are being committed, are a higher priority for community safety. Police departments are usually quite effective in persuading the local judges to make orders for outpatient commitment rarely if at all.

There has been much more success nationally in implementing mental health courts were a person is required to accept treatment for their mental illness as a condition of probation

or parole. This is more acceptable to local law enforcement because it helps keep mentally ill people out of their jails, more acceptable to the courts because it provides them with an additional option or disposition of the case, and more acceptable to the mentally ill person who is usually more ready to admit they have committed a crime then they are so to admit that they must have treatment is a civil probate requirement because they might do something dangerous in the future.

Regarding research outcomes for outpatient commitment, the most recent systematic review of outpatient commitment published up until November 2009 by the Cochrane Collaboration suggests that compulsory community treatment may not be an effective alternative to standard care. This research is on the effectiveness of compulsory community treatment for people with severe mental illness through a systematic review of all relevant randomized controlled clinical trials. Only two relevant trials were found and these provided little evidence of efficacy on any outcomes such as health service use, social functioning, mental state, quality of life or satisfaction with care. No data were available for cost and unclear presentation of data made it impossible to assess the effect on mental health state, and most aspects of satisfaction with care. In terms of numbers needed to treat, it would take 85 outpatient commitment orders to prevent one readmission, 27 to prevent one episode of homelessness, and 238 to prevent one arrest.

The reviewers concluded that Compulsory community treatment results in no significant difference in service use, social functioning or quality of life compared with standard care. People receiving compulsory community treatment were, however, less likely to be victims of violent or non-violent crime.

It is unclear whether this benefit is due to the intensity of treatment or its compulsory nature. There have been five new research studies made available since November 2009 awaiting inclusion in the review may alter the conclusions of the review once assessed. There is no Cochrane review available regarding mental health courts available at this time, however, the Cochrane review of drug courts is somewhat more hopeful concluding that they promising results for the reduction of drug use and criminal activity in drug using offenders.

The Cochrane Collaboration is an international network of evidence based practice reviewers. They are an independent, not-for-profit organization, funded by a variety of sources including governments, universities, hospital trusts, charities and personal donations. A systematic review is a high-level overview of primary research on a particular research question that tries to identify, select, synthesize and appraise all high quality research evidence relevant to that question in order to answer the question. There has been much more federal support available for implementing drug courts than there has been for mental health courts.

In view of the lack of compelling evidence for the effectiveness of mandated outpatient commitment and the reluctance of local law enforcement agencies to be involved, the best current strategy for increasing the availability of mandatory treatment for persons with serious mental illness would be to increase federal support for mental health courts -- which are easier to implement and more acceptable to both local law enforcement and the persons being mandated into treatment.

6) **We need additional block grant funds directed at reducing the devastating impacts of various forms of trauma (e.g., impact on individuals of natural disasters, child abuse, violence) that lead to mental health disorders in our society.**

Over 90 percent of public behavioral health clients have been exposed to trauma, and most have multiple experiences of trauma.

Millions of Americans suffer traumatic events due to range of incidents – rare or consistently over time. Over 90 percent of public behavioral health clients have been exposed to trauma, and most have multiple experiences of trauma.

SAMHSA has tried through limited funds to address the behavioral health impact of trauma by developing public health approaches to trauma that strengthens surveillance, screening, and treatment that better responds to the needs of those affected. Reducing the impact early is possible and cost-effective, and SAMHSA should receive increased funding to address the needs of people affected by traumatic episodes.

7) **Treat the Appalling Rate of Premature Death Among Persons with Serious Mental Illness in the Public Mental Health System like the National Epidemic It Is –**

It is been over 10 years now since research showed that persons in the public mental health system, most of whom have serious mental illness, are dying on average 25 years younger than the general population. This is a higher death rate than experienced currently by persons with HIV and on a par with sub-Saharan Africa. But what is overlooked is that over 80 percent of the premature deaths and years of life lost are due to co-occurring chronic medical conditions such as diabetes and heart ailments, not suicide or accidents. There is no federal agency that is routinely and systematically tracking this epidemic, let alone addressing it.

Key recommendations in this area include:

a. Persons with serious mental illness should be federally designated as a "distinct at risk health disparities" population;

b. The CDC and SAMHSA should develop, implement, and fund national annual surveillance of the mortality rates and causes of death in persons with serious mental illness; and
c. HHS and SAMHSA should develop, implement, and fund a national strategy specifically for reducing premature death among persons with serious mental illness by promoting and accelerating the integration of behavioral health care and general medical care – and integration of preventive measures on the health care side and mental health side.

Thank you again for the opportunity to present my views on these critically important issues that the Committee is tackling. I would be happy to assist the Committee in my various roles, to help you implement solutions to addressing the needs of people with serious mental illness.

They deserve national attention and leadership at all levels.