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Substance Abuse and Mental Health Services Administration**

Responses to Questions for the Record

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

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

The Honorable Tim Murphy

- 1. In conversations with GAO, you mentioned the work of the Behavioral Health Coordinating Council (BHCC), established in 2010.**
- a. During the course of GAO’s work on this report, it was announced that BHCC would establish a subcommittee devoted to addressing serious mental illness. Is this a result of the GAO’s or this Committee’s inquiries on serious mental illness?**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Honorable Marsha Blackburn

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

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

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

support administrative costs for SAMHSA.³

The Honorable David McKinley

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

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

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

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

The Honorable Morgan Griffith

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

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

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

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

Examples of other SAMHSA investments in this area include:

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

⁵ Additional information available at <http://actionallianceforsuicideprevention.org/>.

⁶ The app is available at <http://store.samhsa.gov/product/SAMHSA-Suicide-Safe-Mobile-App/PEP15-SAFEAPP1>.

The Honorable Chris Collins

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

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

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

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

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

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

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

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

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

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

⁸ <http://www.nrepp.samhsa.gov>.

⁹ These toolkits are available from SAMHSA at <http://store.samhsa.gov/list/series?name=Evidence-Based-Practices-KITs>.