

May 5, 2014

Sydne Harwick  
 Legislative Cleark  
 Committee on Energy and Commerce  
 2125 Rayburn House Office Building  
 Washington, DC 20515

**The Honorable Joseph R. Pitts**

Question 1

**How much in federal dollars did Mental Health America (MHA) and its affiliates receive over the past three years (in the form of grants, cooperative agreements, contracts, etc.)? Which federal agencies administered this funding and under what statutory authorities? In each of the past three years, what fraction of MHA’s—and approximately what fraction of its affiliates’—annual budgets did such federal funding constitute?**

Because Mental Health America (MHA) affiliates are separately incorporated entities, we can’t provide a definitive answer to this question. We ask individual affiliates to identify the percent of the budget that comes from government grants or contracts, but we do not ask them to break this down by federal or state, county, or city amounts. In addition, some states have elected a structure of affiliation where only the state offices affiliates directly with our national office, and local affiliates do not provide this information directly to the national office. MHA affiliates are listed on our website.

Each year, we summarize publicly available versions of affiliate tax returns (990s) and consolidate that information. We usually separate government support (which includes federal, state, and local grants, contracts or cooperative agreements) and program service revenue (which includes both federal reimbursements for services as well as revenue generated from certifications, conferences and non-federal program service revenue). There is no way for us to differentiate which program service revenue comes from the federal government versus what is generated by the affiliate from other sources, nor is there a way for us to identify what government grants come from the federal government and which come from state or other local governments.

Over the past 3 years, we have recorded, for the field (data lag by 1-2 years):

	2012	2011	2010
<b>Government Grants</b>	125,831,547	124,925,361	125,626,144
<b>Program Service Revenue</b>	77,144,894	78,294,773	102,506,241
<b>Total Revenue</b>	243,684,603	246,606,014	278,695,326

Given that the vast majority of the work that the affiliates do is at the state level, we estimate that the vast majority of the government grants come from state and local governments.

For the national office of Mental Health America, over the past 3 years we have recorded:

	2013	2012	2011
<b>Government Grants</b>	319,673	0	0
<b>Government Contracts</b>	106,864	309,336	689,441
<b>Total Government Revenue</b>	426,537	309,336	689,441
<b>Total Revenue</b>	3,014,703	2,651,887	3,758,958
<b>% of Total Budget</b>	<b>14%</b>	<b>12%</b>	<b>18%</b>

We are more often subcontractors than prime contractors on government contracts.

Agencies included:

#### SAMHSA

- HHSS280200900006C – SAM116059
- HHSS283200700029I/HHSS28342002T
- HHSS283200700020I, Task Order HHS28342002T
- HHSS28320070008I, Task Order HHSS28342002T
- HHSS283200700020I, Task Order HHSS28300001T, Reference 283-07-2001
- HHSS283200700020I, Task Order HHSS28342003T

#### SAMHSA/HRSA

- 1UR1SMO60319-01

#### NIH

- P20MH078188-04, Project 1008680; Task 4; Award 25017, CFDA #93.242

#### CMS

- PPHF – NAVCA130045-01, 93.750

#### Question 2

**In your testimony, you state that “the wholesale abandonment of the PAIMI function would be disastrous in our current systems.” Is there any provision of H.R. 3717 that envisions and/or mandates a “wholesale abandonment” of the original mission of the system established under the Protection and Advocacy for Individuals with Mental Illness Act of 1986?**

H.R. 3717 (under Section 117: Authorization of Appropriations) proposes \$5 million for each of the fiscal years 2014 through 2017 for Protection and Advocacy. Currently the appropriation is \$35 million. This is an eighty-five percent reduction. We interpreted an 85% reduction in funding to indicate a wholesale abandonment of Protection and Advocacy since it would effectively render the P&As unable to fulfill their mission.

Continuing problems with the public mental health systems require effective protection and advocacy services. For example, on May 1, 2014<sup>1</sup> Connecticut settled a law suit which began eight years ago, which

was jointly filed by its state Protection and Advocacy program and the Bazelon Center for Mental Health Law, that ended the practice of housing hundreds of people with mental illnesses in nursing homes in violation of the American's With Disabilities Act. In settling this suit the State also addressed the issue of elderly patents residing alongside people of all ages with serious mental health conditions. The State has agreed to house people in the community and provide intensive wrap-around services for them.

In April the Disability Rights Law Center in Massachusetts (the state's Protection and Advocacy organization) began a new investigation of the Bridgewater State Hospital<sup>ii</sup> over allegations of abuse and neglect and the frequent use of seclusion and restraint for persons with severe mental illnesses. In 2007 the Disability Law Center sued and won concessions from this same institution over its excessive use of solitary confinement for those housed in its forensic unit. Also in April Kentucky's Protection and Advocacy agency advocated for the State to provide more appropriate oversight to a notorious group home that housed mentally ill men<sup>iii</sup>. The deplorable conditions that were revealed from the investigation included residents covered with insect bites, bare beds and filthy and broken plumbing. Without on-going support of Protection and Advocacy horrific abuses such as these would likely not be exposed or remediated.

### Question 3

**In your testimony, you state that “none of the research to date has estimated the number of persons who avoid any contact with the treatment system as a result of the potential coercion.” You also assert that “our treatment systems should be welcoming rather than frightening.” If, as you say, studies demonstrating the chilling effect of civil commitment laws on the seeking of treatment do not presently exist, on what basis do you oppose Assisted Outpatient Treatment as a tool for treating the seriously mentally ill when other research to date has shown its effectiveness?**

In the testimony, I was citing the research on Assisted Outpatient Treatment (Involuntary Outpatient Commitment) which has not estimated the degree to which these programs cause individuals with severe mental illnesses to avoid engagement in the treatment system. However, there are many studies that conclude that mandated treatment can cause individuals to avoid the treatment system. For example, a multi-site study done in Chicago, IL, Durham, NC, San Francisco, CA, Tampa, FL, and Worcester, MA demonstrated that for more than one-third of people across these sites coercion, or the fear of coercion, had a negative effect on treatment adherence, as well as damaging the therapeutic alliance between patient and clinician<sup>iii</sup>. This study and others like it found that the effects of coercion potentially outweigh any benefits which may have come from mandated treatment<sup>iii</sup>.

A landmark study in California found that 47% of people with mental illness avoided seeking treatment for fear of involuntary commitment. The percentage of people avoiding treatment rose to more than half (55%) if they had previously been subject to involuntary commitment<sup>iii</sup>.

Further studies that show benefits from mandated treatment, such those done on New York State's Kendra's Law, conclude that it is difficult to attribute positive outcomes for people subject to this law to being under court order rather than to having access to intensive services<sup>iii</sup>. Evidence indicates that coercion can stifle consumer engagement with ambiguous evidence regarding its benefits in accountable, engagement oriented systems.

## Question 4

**Dr. Tom Insel, Director of the National Institute of Mental Health (NIMH), informed the Subcommittee last year that treatment can reduce the risk of violent behavior 15-fold in persons with serious mental illness. In your testimony, you assert that “there is no simple link between mental illness and violence.” Do you believe that, contrary to what Dr. Insel has told the Subcommittee, there is no simple link between untreated serious mental illness and violence?**

I don't interpret Dr. Insel's comments as indicating that a simple link between mental illness and violence exists. I interpret his comment as indicating that persons with severe mental illnesses who are effectively treated are less likely than persons who are not effectively treated or untreated to engage in violence. I have no quarrel with that conclusion. However, it doesn't address the full range of antecedents of violence.

One of the best analyses of the antecedents to violence was conducted by Swanson and his colleagues (Swanson, et al., 2002, American Journal of Public Health, Vol. 92, No. 9, 1523-1642) who demonstrated that the annual rate of violence among persons with severe mental illnesses in near zero if they do not have a substance use disorder, are not exposed to violence in their neighborhood or are not victims of violence themselves. However, as individuals accrue these other characteristics, the likelihood of some violent act increased to near 30% for persons who were victims of violence, used substances and lived in violence prone neighborhoods. Therefore, it is these additional characteristics that account for the likelihood of violence and not simply having a severe mental illness. Studies like Swanson's lead us to conclude that there is no simple relationship between mental illness and violence.

## Question 5

**In your testimony, you correctly state that H.R. 3717 “seeks to limit services supported by SAMHSA to those that have an evidence base.” On March 9, 2009, President Obama released a memorandum for the heads of executive departments and agencies assigning to the Director of the Office of Science and Technology Policy “the responsibility for ensuring the highest level of integrity in all aspects of the executive branch’s involvement with scientific and technological processes.” Do you not agree that the activities SAMHSA, a component agency of the Public Health Service, should always be evidence-driven and based on scientifically rigorous research demonstrating their effectiveness?**

SAMHSA has many roles to play in the behavioral health system in the United States. Among these roles is support for the development of novel approaches to better serve the needs of persons with mental and addictive illnesses. In this latter role, it is essential that SAMHSA provide support for as yet untested interventions. However, it is also of critical importance that these innovative approaches be rigorously evaluated so that their key elements, effectiveness and implementation strategies be fully understood. To the degree to which they are proven to be effective, they will become the next generation of evidence based practices. Outside of innovative and rigorously evaluated programs, we believe that behavioral health treatment supported by SAMHSA or any other payer should conform to our best evidence and be delivered with high fidelity to the models that have been shown to work through systematic research.

**The Honorable Michael C. Burgess**

## Question 1

**Earlier this year CMS proposed rulemaking would have dramatically reduced coverage to critical medication used for treating mental health conditions, transplants, and other conditions. I understand that Mr. Murphy's legislation contains provisions that would prevent this from happening in the future. Will you discuss the importance of patients having access to and coverage of the most clinically appropriate pharmaceutical interventions?**

Given the idiosyncratic responses to psychiatric medications that characterize mental illnesses, we believe that access to a full set of medication options should be available to clinicians and their patients as they design treatment plans. We believe that informed consumers and clinicians can make the best decision about which medication work for whom and that arbitrary limitations are likely to ultimately increase costs owing to untoward side effects, decreases in treatment adherence and avoidable crises that may result in expensive and intrusive episodes of residential or hospital care.

Respectfully,  
David L. Shern, Ph.D.  
Senior Science Advisor  
Mental Health America

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<sup>i</sup> Settlement Bars Placement of Mentally Ill in Nursing Homes: *Associated Press*, May 1, 2014: *The Connecticut Law Tribune* <http://www.ctlawtribune.com/id=1202653539696/Settlement-Bars-Placement-Of-Mentally-Ill-In-Nursing-Homes?slreturn=20140402152745>

<sup>ii</sup> New scrutiny for Bridgewater State Hospital after complaints, *Boston Globe*, April 17, 2014 <http://www.bostonglobe.com/metro/2014/04/16/watchdog-group-for-disabled-launches-investigation-troubled-bridgewater-state-hospital/XN2edcSkIgf3mMZ2G1p0NJ/story.html>

<sup>iii</sup> Press Release—Kentucky Protection and Advocacy, April 29, 2014