NSSC

National Shattering Silence Coalition

Speaking Out • Inspiring Change

NSSC is a nonpartisan alliance of family members, individuals suffering from serious brain disorders (SBD), professionals in the trenches, and people who care who are uniting to ensure that brain illness, health, and criminal justice systems count those with SBD, and their families in all federal, state, and local policy reforms. We are voices for the 11.2 million adults and 7 million children living with and dying too young from serious brain disorders.

Position Statement: NSSC Points of Unity #4: End Discrimination: Support the full repeal of the IMD exclusion and call for parity and a right to treatment under Medicaid/Medicare.

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I. INTRODUCTION: What is the IMD exclusion? What are its impacts?

In 1963, the U.S. Congress passed The Community Mental Health Centers Act. It was mistakenly believed then that treatment of persons with serious mental illnesses in a community-based setting, using existing resources and the new psychotropic medications, would be in all cases superior to long-term treatment in a psychiatric hospital. Two years later, with the beginning of the Medicaid program, Medicaid funds were barred from use in the treatment of adults (persons between the ages of 21 and 64) in facilities having more than 16 beds for the specific treatment of mental disorders, a.k.a. Institutions for Mental Disease (IMD). Although Congress included coverage for Alzheimer's disease and intellectual disabilities in Medicaid legislation, it determined that treatment of mental illness in adults was exclusively a state obligation. There was also the concern that if IMD's were included in the Medicaid program, the states would continue to warehouse people in hospitals instead of providing services in the community.

That reasoning has not lived up to the promise, however. Without sufficient funding, most IMD's have closed. Yet communities failed to provide adequate comprehensive community-based services to take their place, leaving those with serious mental illnesses without adequate care. This failure occurred partly due to overly optimistic expectations in regards to the efficacy of the new psychotropic medications, as well as the widespread lack of knowledge about serious mental illnesses (SMI), which we now know are serious brain disorders (SBD). These factors left those who could not be treated in the community neglected and without vital resources for medical care. These, combined with other failures, including an unwillingness of communities to adequately fund a system of care that does not result in ready "cures," has resulted in no comprehensive support system which will permit those with SBD to live successfully in the community. The IMD exclusion is an important factor in this failed system and is the focus of this paper.

Today, Medicaid is the most important safety net for health care, including mental health care. In 2015 it covered only 14% of the adult population, but it covered more than 25% of adults with SBD and almost 20% of adults with substance use disorders (SUD).

II. THE ISSUE: Repeal the IMD Exclusion

The Republican Policy Committee has provided this description of the problem with the IMD exclusion, which focuses solely on its applicability to the Opioid Crisis, but ignores how it also impacts the SBD population.

> Under the Medicaid statute, federal funding cannot be used to finance care for Medicaid beneficiaries aged 21 to 64 receiving mental or substance use disorder care in a residential facility that has more than 16 beds. When a Medicaid-eligible individual is a patient in an IMD, he or she cannot receive Medicaid coverage for services provided inside or outside the IMD. The Medicaid IMD exclusion is one of the few instances in the Medicaid program where federal financial participation cannot be used for medically necessary and otherwise covered services for a specific Medicaid enrollee population receiving treatment in a specific setting. According to the Medicaid and CHIP Payment and Access Commission (MACPAC), "The Medicaid IMD exclusion acts as a barrier for individuals with opioid use disorder to receive residential treatment, which, depending on an individual's treatment plan, might be the most appropriate setting for care."

In response to this deficiency, H.R.5797, the IMD CARE Act, passed by the House of Representatives but not in the Senate. NSSC did not support this bill as it would have only partially lifted the IMD exclusion for people receiving care for substance abuse disorder (SUD). It did not completely repeal the IMD exclusion and would have made adults with SBD (along with those suffering from a stimulant or hallucinogen use disorder) the only groups legally discriminated against in the provision of vital treatment for chronic conditions.

On April 16, 2021, a better bill, H.R. 2611, Increasing Behavioral Health Treatment Act, was introduced in the House of Representatives that fully repeals the IMD exclusion, along with placing requirements for the provision of appropriate treatments and follow up care upon release from IMDs for those living in community settings. NSSC supports this legislation and encourages all Representatives to join as co-sponsors.

III. DISCUSSION: Why the IMD exclusion for mental illness is discriminatory and wrong

A. The IMD exclusion misinterprets the U.S. Supreme Court's Olmstead Decision.

One argument against the reinvigoration of psychiatric hospitals is the perceived requirement, based on the Supreme Court's decision on *Olmstead v. L.C.*, 527 U.S. 581 (1999), that people with disabilities must be housed in the least restrictive setting possible, i.e. - not in a state mental hospital if at all possible. Also, the integration regulation mandate in Title II of the Americans with Disabilities Act requires a "public entity [to] administer … programs … in the most integrated setting appropriate to the needs of qualified individuals with disabilities." Where a community setting is best for the individual under Title II, the court concluded, unnecessary institutional segregation constitutes discrimination *per se*, which cannot be justified by a lack of funding.

NSSC believes that the ADA requirement that disabled people be cared for in the least restrictive environment possible is a laudable goal, but it is a spurious and false argument

against maintaining psychiatric hospitals. Furthermore, just as not providing a community setting due to lack of funding cannot be justified, so, too, not providing a hospital setting when it is the appropriate course similarly cannot be justified by lack of funding. There are people for whom the least restrictive setting *is* a psychiatric hospital. To deny that care also constitutes discrimination *per se*.

In the majority opinion, Justice Ginsburg pointed out, "*The ADA is not reasonably read to impel States to phase out institutions, placing patients in need of close care at risk.*" Further along in her summary, she states, "*Some individuals, like L. C. and E. W. (the two women whose care was the concern of this Supreme Court decision) in prior years, may need institutional care from time to time to stabilize acute psychiatric symptoms. For others, no placement outside the institution may ever be appropriate*."

B. Section 1115(a) SMI/SED demonstration opportunities have not been taken advantage of by the majority of states.

In November of 2018, all state Medicaid Directors received new guidance informing them, among other things, of the opportunity to apply for Section 1115(a) SMI/SED demonstration opportunities. Though Section 1115(a) waivers for SUD are quite popular, with 32 states approved and 4 states pending, as of October 8, 2021, only seven states had approved Section 1115(a) SMI/SED demonstration opportunity programs and six had pending waiver requests.

At this point, we can only speculate as to why more states are not applying for the SMI/SED waivers. In terms of political will, SUD has, before covid, been a popular cause. Some states may be unwilling or unable to meet the requirements to qualify for the waivers. The state of Maine did not apply for the SMI/SED waiver based on Disability Rights of Maine's argument claiming it was "in violation of the ADA, Olmstead, and the Settlement Agreement." Their arguments are misguided as proven elsewhere in this position statement. It's time to end this layer of bureaucracy and eliminate the IMD exclusion.

C. The IMD exclusion violates existing law: the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) or Parity Act.

The IMD exclusion discriminates against providing treatment to adults between the ages of 21 and 64 who've been stricken with a chronic brain illness that most often begins when they are young adults. In addition to being unethical and unjust, this discrimination is a violation of the mental health parity requirement of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) or Parity Act, passed in 2008, and later its subsequent inclusion in provisions of the Affordable Care Act (ACA). Over 11.2 million adults are living with SBD in America. The IMD exclusion has been used to discriminate against this population for 53 years. These diseases are medical diseases of the brain and must be treated with the same care and attention as any other medical disease of the brain, such as Alzheimer's or Parkinson's.

As pointed out above, Congress itself, in the online summary of the failed H.R.5797, admits that federal funds have been forbidden to pay for "medically *necessary* treatment" for specific populations; i.e. discriminating against certain people. According to the Medicaid and CHIP Payment and Access Commission (MACPAC), "The Medicaid IMD exclusion is a barrier for receiving residential treatment, …which, depending on an individual's treatment plan, may be the most appropriate setting for care." These statements are just as true, if not more so, for the population struggling with SBD.

The Intergovernmental Serious Mental Illness Coordinating Committee (ISMICC), in the report "The Way Forward," delivered to Congress in December 2017, established recommendations that relate to the IMD exclusion and its effects:

> #5.4 Eliminate financing practices and policies that discriminate against behavioral health care.
>
> #2.2 Develop a continuum of care that includes adequate psychiatric bed capacity and community-based alternatives to hospitalization

D. The IMD exclusion imposes unethical and unjust consequences: jail and death while incarcerated.

It is unethical to deny needed treatment. Those with an untreated SBD often act out their delusions in public and end up in the judicial system. Using our jails to house people suffering from SBD and preventing treatment for their illness is cruel and barbaric, and has sent our nation back to the practices typical in the 1800s.

In 2006, the US Department of Justice (DOJ) found that about ½ of state and federal prisoners and 2/3 of those held in local jails had mental health problems. These facilities are not equipped for and do not have the professional staffing levels needed to provide humane and appropriate care for these prisoners. Documentation of violence and humiliation suffered at the hands of both prison staff and other prisoners abound. Solitary confinement is overused, cruel, and further compounds the destabilization of a person's psychotic state. This is cruel and unusual punishment for the crime of suffering from a brain disorder.

Gary A. Harki, writing for The Virginian-Pilot, August 23, 2018, after months of investigation of this problem nationwide, wrote one of the best descriptions of the problem to date in "Horrific deaths, brutal treatment: Mental illness in America's jails: A comprehensive Virginian-Pilot investigation". In the course of the investigation, the team found that from 2010 to 2018 there were at least 404 deaths of jail inmates that were known to have a mental illness before their incarceration. Due to poor recordkeeping, there are likely many more. In Texas, which keeps better data than other states, the Virginian-Pilot study uncovered 36 deaths of mentally ill inmates in Texas jails, while the Texas Department of Corrections in their own compilation found 55 deaths. Only six of those appeared in both reports, indicating how likely even the best estimates of deaths of people with SBD inmates are grossly undercounted. The stories

recounted in the article and elsewhere testify to the fact that lack of medication, use of the wrong medication, or torture and neglect in solitary confinement directly result in these deaths.

The article notes that beginning "*October 2019, the Bureau of Justice Assistance will start collecting more accurate data on deaths in police and jail custody. The collection, which has been long delayed, was prompted by the 2013 Death in Custody Reporting Act, sponsored by U.S. Rep. Bobby Scott, D-Newport News*." The required data is to include "*basic demographic information, as well as the date, time and location of death, the law enforcement agency involved and a brief description of the circumstances."* But it still will not specifically collect data on whether the person was suffering from a SBD.

Because of the IMD exclusion, jails have become the new asylums, and are just as horrific as conditions of the 1800s' asylums; the conditions that were to be alleviated with community treatment. The passing of the IMD exclusion in 1965 resulted in the closing of most state psychiatric hospitals and a great reduction in available crisis and long-term care beds. In 1955 there were more than 500,000 state psychiatric hospital beds, a rate of 337 per 100,000 population. In 2018 the rate has declined to less than 12 per 100,000 population. It has been determined that to meet the needs of the SBD population, there should be 50 beds available per 100,000 population. Psychiatric hospitals needed to be brought up to date and made more humane, not be closed. The brain-ill population has not just disappeared. People suffering from serious brain disorders, unable to care for themselves and without the services of a psychiatric hospital, have largely ended up in the judicial system or homeless.

In the 2017 book *Insane Consequences,* DJ Jaffe points out that nationwide there are now more than 390,000 persons with SBD incarcerated in our jails and prisons. This figure is the result of an almost direct transfer, over recent decades, of the mentally ill from hospitals to jails and prisons where there is little to no appropriate treatment of their illness. Another 755,000 with SBD are on probation or parole. The National Council for Behavioral Health projects that another 84,000 people are chronically homeless due to untreated brain illness, addiction, or other disabilities. We are aware of the abuse and neglect that occurred in the asylums of the last century but transferring those with SBD to jail or the streets is an even greater form of abuse and neglect. What is needed is funding, including Medicaid payments, for modern, community-based hospitals, for a continuum of care, and long-term supportive housing for this neglected population.

E. Lack of psychiatric beds results in poor care and worse outcomes.

The IMD exclusion limits facilities to 16 beds for express treatment of psychiatric illness. This limitation does not allow for the economies of scale needed to stay in business or provide effective care. Those in crisis who manage to get to an emergency room are often left "boarding" in the ER, waiting for a psychiatric bed to become available, or simply tranquilized and released without follow-up care. Unless facility providers are paid, they cannot provide

much-needed long-term care for adults suffering from SBD, with or without opioid addiction. Thus adults with SBD experience long delays in getting care and are denied beds.

It is well documented that there is a much poorer prognosis for those with SBD who do not receive prompt, early intervention and treatment. Every episode causes further deterioration of the brain and other organs resulting in irreparable damage. Making this population wait for beds worsens their long-term prognosis as well as their health and safety, and the safety of the community.

The IMD exclusion is the primary reason for the severe shortage of psychiatric inpatient beds. Data collected by the Treatment Advocacy Center (TAC) reveals that from 1955 to 2016, the number of state hospital beds in the United States had plummeted almost 97%. By 2014, ten times more people with SBD were in prisons and jails than in state psychiatric hospitals, a circumstance widely attributed to the shortage of beds to provide timely treatment.

In 2016, a new “managed care rule” from the Centers for Medicare and Medicaid Services (CMS) allowed states to receive “capitation” payments to managed care plans to cover IMD care for up to 15 days. However, the allotted fifteen days is often inadequate in ensuring that the choice of medication and other treatments is going to be effective for lasting improvement for SBD. One must be lucky enough to live in a state using this exemption rule and to have prompt access to a hospital bed. When released prematurely individuals too often quickly decompensate, because even when the illness is caught early, finding the right medication to treat SBD is a matter of trial and error. It may take weeks or longer for a new medication to show its effectiveness, and if it is not effective, the doctor must try another medication until an effective medication is found. This process can evolve into months when a person has remained untreated for a long period of time. Medicare's current hospitalization limit of 30 days is often not enough time to treat and stabilize people suffering from chronic SBD or co-occurring disorders.

Currently, according to data from the Treatment Advocacy Center (TAC), in any given year, approximately 4 million people with SBD are untreated. In other words, nearly half are unable to secure proper treatment in this country. That statistic is appalling and unacceptable and can only be defined as grossly negligent. Failure to provide prompt inpatient psychiatric hospitalization when needed causes an excruciatingly inhumane and expensive, fiscally irresponsible pattern of cycling people in and out of the revolving doors of emergency rooms, hospitals, homelessness, and jails. Family members of those with SBD also experience the collateral damage inflicted by a government that has turned a blind eye to the suffering of their loved ones for decades.

It is estimated that 18.7 million adults battled a SUD in 2017.[1] 8.5 million of those had a co-occurring disorder or COD (a brain illness and a co-occurring SUD). SAMHSA determined that fewer than 11.8% of those with COD were receiving treatment for both disorders *and 36%*

[1] https://www.samhsa.gov/data/report/2017-nsduh-annual-national-report

received no treatment at all.[2] Successful treatment of their CODs requires treating *both* their SUD *and* their SBD.

SAMHSA has identified that there is only about a 5-year window of opportunity for the prevention of co-occurring substance abuse after the onset of a brain disorder. Untreated SBD leads to more severe and treatment-resistant illnesses and the development of CODs. By far, the most common connection between untreated brain illness and substance abuse is self-medication. In many cases, the SUD is a symptom of the SBD and would not have developed had the patient received prompt, consistent care for their illness.

F. The IMD exclusion costs the public more than appropriate treatment.

We hear, in debates at the state level about expanding Medicaid and eliminating the IMD exclusion, that paying for hospital treatment for those with SBD is cost-prohibitive. But we argue that the costs of not paying for treatment are likely much greater. Many authors have attempted to quantify the potential costs of treatment and to compare them to the current costs to society of not using Medicaid/ Medicare funds for treatment of SBD/SUD. In 2021, the Schizophrenia and Psychosis Action Alliance (S&PAA) published an extensive review of peer-reviewed published studies, Societal Costs of Schizophrenia & Related Disorders, in which it estimated the annual direct and indirect costs to society and families. S&PAA points out that the data available is not comprehensive but justifies further research to gain a more complete perspective on the unmet needs of those with SBD. Their findings showed the direct and indirect costs of having a serious brain illness are over $281 billion *more* annually than the costs of persons not affected and that many cases go untreated. Although making appropriate and effective treatment available to all who require it would impact the direct costs of treatment, enabling people to reach a measure of recovery and live full productive lives would greatly offset those increases as well as reduce the stress on the criminal justice systems and services for the homeless.

Previously, the ISMICC report to Congress also pointed out that programs and policies need to be guided by more comprehensive data to improve the quality of care and outcomes. Congress should authorize SAMHSA to undertake a comprehensive study of the costs of care vs. costs of failure to provide timely and appropriate treatment or as NSSC coins it, the #CostOfNotCaring, as well as the efficacy of treatment protocols. Using good data would facilitate efficiencies by narrowing payments to evidence-based practices.

Many costs are invisible. Because access to appropriate treatment is so limited, many families choose to shelter their ill loved ones while attempting to get help for them. They do this rather than abandon their loved ones to the streets, or risk the abuses that await their loved ones in jail or prison. Caring for their loved ones at home exposes them to potential grave violence and also often results in financial hardships. Family caregivers lose work and may lose their jobs if they

[2] https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHFFR2017/NSDUHFFR2017.pdf

are absent too often dealing with emergencies or court appearances. They resign from their jobs when it's clear their family member cannot be left unattended and no respite can be found. They have to pay for repairs to their property when violent outbursts occur. They pay for bail bonds or legal defense for their loved ones. Because of danger to others in the home, some parents pay for private apartments or private treatment, both inpatient and outpatient, until their money runs out. These caregivers experience unmeasurable grief and stress while battling the dysfunctional health system in vain attempts to get help for them. They do this rather than abandon their loved ones to the streets, or risk the abuses that await their loved ones in jail or prison. The S&PAA report estimates the caregiver burden and unpaid labor to be $104.5 billion.

Many of those who suffer from SBD do not qualify for SSDI (Social Security Disability Insurance) because their illness struck when they were too young to have worked enough time in the system to be entitled to SSDI. They are forced to accept the lower-paying SSI (Supplemental Security Income) or a combination of SSI and SSDI. If so, their benefits are limited to a range between $750 per month (if only SSI), and the minimum for SSDI which averages $1,197 a month (for 2018). These amounts—even with a rent subsidy and even with food stamp benefits of $192 a month—are not enough to cover rent and living expenses, even for a mentally ill person who is well enough to live in their own space. Families end up supplementing their children's income with food, gas, automobiles, clothing, and so on to keep their children housed and out of jail. The S&PAA report estimates this societal cost to be $5.1 billion.

Because those with untreated SBD are at high risk for other chronic diseases such as diabetes, heart disease, lung disease, and infections, leaving their illnesses untreated increases costs for Medicaid and other public health systems that deliver non-IMD services.

One difficulty, when identifying and quantifying the savings from repealing the IMD exclusion, is that the costs and savings are borne by so many different agencies. Diverting a person from the criminal justice system, or helping him avoid it in the first place, saves money, but that money does not flow back to Medicaid or state or county mental health systems where it could be used to provide appropriate treatment and supportive housing to more people. Costs now borne by families and businesses due to lost productivity aren't counted anywhere. The costs of dealing with homelessness are borne by local governments and businesses who have no easy way of being compensated.

Our lawmakers must take all of these costs into account when considering the costs and benefits of eliminating the IMD exclusion.

G. The IMD exclusion imposes social costs: public and family tragedies.

Tragic incidents that arise from untreated SBD are increasing. Psychiatrist E. Fuller Torrey estimates that up to 10% of all US homicides and approximately half of all mass killings are due to untreated serious mental illness. Between 1982 and 2012, 63% of mass shooters had a mental illness, according to *Mother Jones*. This dynamic continues to play out in the national

news all too frequently now. We need a more structured way to care for someone with an emerging brain illness so that they receive adequate care before they act out.

In addition, according to data from the Treatment Advocacy Center (TAC), half of those living with schizophrenia or bipolar disorder will attempt suicide at some point in their life. Many go homeless and/or wind up incarcerated. Yet suicide awareness campaigns ignore this.

In 2008 one study showed that more than 26,000 persons with SBD were incarcerated for murder. Parents and other family members are the most likely victims. 29% of family homicides were perpetrated by a family member with a SBD. In 2013 alone, over 1,100 people were killed by a family member with SBD usually when medication was stopped for various reasons. Police and other public servants are also at greater risk of injury and death at the hands of a person with untreated SBD. The Treatment Advocacy Center (TAC) and the National Sheriffs' Association (NSA) conducted a joint study in 2013 finding that at least half of all attacks on law enforcement officers and 20% of officer fatalities were by people with mental illness, many of whom had ceased taking medication. This preventable violence destroys not only the life of the victim, but also the life of the ill person, and causes emotional and financial devastation to both of their families who are left to deal with the fall-out.

TAC released a report, *Overlooked in the Undercounted - The Role of Mental Illness in Fatal Law Enforcement Encounters*, in December of 2015. From their report:

- *The risk of being killed while being approached or stopped by law enforcement in the community is 16 times higher for individuals with untreated serious mental illness than for other civilians.*
- *By the most conservative estimates, at least 1 in 4 fatal law enforcement encounters involves an individual with serious mental illness. When data have been rigorously collected and analyzed, findings indicate as many as half of all law enforcement homicides ends the life of an individual with severe psychiatric disease.*
- *The arrest-related death program operated by the Bureau of Justice Statistics within the US Department of Justice is the only federal database that attempts to systematically collect and publish mental health information about law enforcement homicides. The program was suspended in 2015 because the data available to the agency was not credible enough to report.*

Repealing the IMD Exclusion, allowing for early intervention and appropriate treatment would decrease the likelihood of law enforcement interaction. This may prove to be the most practical strategy for reducing fatal police encounters in the United States.

By eliminating the IMD exclusion, the Treatment Advocacy Center estimates that the country would eliminate:

- 50% of mass killings
- 29% of family homicides
- 10% of all homicides
- 20% of law enforcement fatalities
- and over 40,000 suicides.

These tragedies and emotional and financial stress on families and communities would be largely preventable by simply providing needed treatment, which may require inpatient care for many weeks.

Ending the IMD exclusion is a crucial first step in preventing this collateral suffering.

H. Repealing the IMD exclusion would immediately improve access to care for those with SBD's.

Eliminating the IMD exclusion and allowing appropriate treatment in the most appropriate setting eliminates the cost of providing a jail for nearly 400,000 people with SBD currently in the prison population, and takes many of the estimated up to 325,000 people with SBD off the streets, greatly reducing the burden to local, county, and state governments of caring for our homeless population.

IV. CONCLUSION

Modern investigation techniques show that serious mental illnesses are biological diseases of the brain. The over 11.2 million people suffering from SBD deserve the same opportunity to receive the compassionate care provided by Medicare/Medicaid for all other medical diseases. Using our jails to warehouse those with SBD while preventing treatment repeats the cruel and barbaric practices typical in the 1800s.

There is a dire need for more treatment beds for those with SBD. Denial and delay of care worsen the condition and lead to adverse changes in the brain. Denying care is not a cost-saving, as, in the absence of effective care, costs will be even higher, including costs to the health care system, the criminal justice systems to which patients are diverted in lieu of treatment, and to a range of local and state governments who deal with the homeless with SBD.

By eliminating the IMD exclusion, as proposed in H.R. 2611, the US and individual states can achieve immeasurable alleviation of human suffering and do so in a very cost-effective manner. If we give it a chance, treatment can work, though sometimes it takes time and experimentation, and it will prevent many societal problems that result from untreated SBD.

Resources:

"Horrific deaths, brutal treatment: Mental illness in America's jails: A comprehensive Virginian-Pilot investigation." *The Virginian-Pilot*, Gary A. Harki, August 23, 2018. Horrific deaths, brutal treatment: Mental illness in America's jails - The Virginian-Pilot (pilotonline.com)

Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State | KFF https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/

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https://www.ranzcp.org/Files/Publications/RANZCP-Serious-Mental-Illness.aspx

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https://www.northcarolinahealthnews.org/2013/07/01/nc-state-study-shows-why-it-costs-less-to-treat-mentally-ill-than-incarcerate-them/

Insane Consequences: How the Mental Health Industry Fails the Mentally Ill. D.J. Jaffe, 2017, Prometheus Books, Amherst, NY.

Crazy: A Father's Search Through America's Mental Health Madness. Pete Earley, 2006, Penguin Group Inc., New York, NY.

http://www.treatmentadvocacycenter.org/evidence-and-research/learn-more-about/3696

http://www.treatmentadvocacycenter.org/key-issues/violence