

**WHERE HAVE ALL THE PATIENTS GONE?
EXAMINING THE PSYCHIATRIC BED SHORTAGE**

HEARING
BEFORE THE
SUBCOMMITTEE ON OVERSIGHT AND
INVESTIGATIONS
OF THE
COMMITTEE ON ENERGY AND
COMMERCE
HOUSE OF REPRESENTATIVES
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¹ The article is available at <http://docs.house.gov/meetings/if/if02/20140326/101980/hhrg-113-if02-20140326-sd004.pdf>.

WHERE HAVE ALL THE PATIENTS GONE? EXAMINING THE PSYCHIATRIC BED SHORTAGE

WEDNESDAY, MARCH 26, 2014

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 10:02 a.m., in room 2123 of the Rayburn House Office Building, Hon. Tim Murphy (chairman of the subcommittee) presiding.

Present: Representatives Murphy, Burgess, Blackburn, Harper, Griffith, Johnson, Ellmers, DeGette, Braley, Schakowsky, Butterfield, Castor, Tonko, Green, and Waxman (ex officio).

Staff present: Leighton Brown, Deputy Press Secretary; Karen Christian, Chief Counsel, Oversight and Investigations; Noelle Clemente, Press Secretary; Brad Grantz, Policy Coordinator, Oversight and Investigations; Brittany Havens, Legislative Clerk; Sean Hayes, Counsel, Oversight and Investigations; Alan Slobodin, Deputy Chief Counsel, Oversight; Sam Spector, Counsel, Oversight and Investigations; Tom Wilbur, Digital Media Advisor; Jessica Wilkerson, Legislative Clerk; Brian Cohen, Democratic Staff Director, Oversight and Investigations, and Senior Policy Advisor; Hannah Green, Democratic Staff Assistant; Elizabeth Letter, Democratic Press Secretary; Karen Lightfoot, Democratic Communications Director and Senior Policy Advisor; Anne Morris Reid, Democratic Senior Professional Staff Member; and Stephen Salisbury, Democratic Investigator.

OPENING STATEMENT OF HON. TIM MURPHY, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. MURPHY. Good morning. I now convene this morning's hearing entitled "Where Have All the Patients Gone? Examining the Psychiatric Bed Shortage."

Right after the December 14, 2012, elementary school shootings in Newtown, Connecticut, the Subcommittee on Oversight and Investigations began a review of federal programs and resources devoted to mental health and serious mental illness. Recent events have shown the continuing importance of this inquiry, including the September 2013 Navy Yard shooting just a couple of miles from where we sit this morning, in Washington, D.C. Other tragic cases, like Seung-Hui Cho, James Holmes, Jared Loughner, and Adam

Lanza, all exhibited a record of untreated severe mental illness prior to their crimes. It is a reflection of the total dysfunction of our current mental health system that despite clear warning signs, these individuals failed to receive inpatient or outpatient treatment for their illnesses that might have averted these tragedies. And they all leave us wondering, what would have happened if—

What would have happened if Aaron Alexis was not just given sleeping pills at the VA hospitals, or if there was hospital bed or outpatient treatment available for others who later became violent, involved in a crime, unable to pay their bills, or tossed out on the street?

Part of the problem is that our laws on involuntary commitment are in dire need of modernization. It is simply unreasonable, if not a danger to public safety, that our current system often waits until an individual is on the brink of harming himself or others, or has already done so, before any action can be taken. The scarcity of effective inpatient or outpatient treatment options in the community, as illustrated by the premature release of Gus Deeds, son of Virginia Senator Creigh Deeds, from emergency custody because of the lack of psychiatric hospital beds, is also to blame, and it is a sad, sad ending. In our heart we cannot begin to imagine a parent's grief when told there is no place for your son or daughter to get help.

Nationwide, we face an alarming shortage in inpatient psychiatric beds that, if not addressed, will result in more tragic outcomes. This is part of the long-term legacy of deinstitutionalization, the emptying out of State psychiatric hospitals resulting from the financial burden for community-based care being shifted from the State to the Federal Government. With the deinstitutionalization, the number of available inpatient psychiatric beds has fallen considerably. The number of beds has decreased in the 1950s from 559,000 to just 43,000 today. Back in the 1950s, half of every hospital bed was a psychiatric bed. We needed to close those old hospitals that had become asylums, lockups and, quite frankly, they were dumping grounds.

But where did all the patients go? They were supposed to be in community treatment. They were supposed to be on the road to recovery. But for many, that simply did not happen.

The result is that individuals with serious mental illness who are unable to obtain treatment through ordinary means are in too many cases homeless or entangled in the criminal justice system, including being locked up in jails or prisons.

Right now, the country's three largest jail systems in Cook County, Illinois, Los Angeles County; and New York City have more than 11,000 prisoners receiving treatment on any given day and are, in fact, the largest mental health treatment facilities in the country. These jails are many times larger than the largest State psychiatric hospitals.

Not surprisingly, neither living on the streets nor being confined to a high-security cellblock are known to improve the chances that an individual's serious mental illness will stabilize, let alone prepare them, where possible, for eventual reentry into the community, to find housing, to find jobs, and to find confidence in their future.

It is an unplanned, albeit entirely unacceptable consequence of deinstitutionalization that the State psychiatric asylums, dismantled out of concern for the humane treatment and care of individuals with serious mental illness, have now effectively been replaced by confinement in prisons and homeless shelters and tied to hospital beds.

What can we do earlier in people's lives to get them evidence-based treatment, community support, and on the road to recovery, not the road to recidivism? Where is the humanity in saying there are no beds to treat a person suffering from acute schizophrenia, delusions, agitation, and aggression and what they are offered is sedation and being restrained in ER hospital bed for days?

This morning, to provide some perspective on the far-reaching implications of the current psychiatric bed shortage and to hear some creative approaches to address it, we will be receiving testimony from individuals with a wealth of experience across the full range of public services consumed by the seriously mentally ill across our Nation. These include Lisa Ashley, the mother of a son with serious mental illness who has been boarded multiple times at the emergency department; Dr. Jeffrey Geller, a psychiatrist and co-author of a report on the trends and consequences of closing public psychiatric hospitals; Dr. Jon Mark Hirshon, an ER physician and Task Force Chair on a recent study of emergency care compiled by the American College of Emergency Physicians; Chief Mike Biasotti, immediate past President of the New York State Association of Chiefs of Police and parent of a daughter with serious mental illness; Sheriff Tom Dart, of the Cook County, Illinois, Sheriff's Office, who oversees one of the largest single site county pre-detention facilities in the United States; the Hon. Steve Leifman, Associate Administrative Judge, Miami-Dade County Court, 11th Judicial Circuit of Florida; Gunther Stern, Executive Director of Georgetown Ministry Center, a shelter and clubhouse caring for Washington D.C.'s homeless; Hakeem Rahim, a Mental Health Educator and Advocate; LaMarr Edgeron, a Clinical Mental Health Counselor and Director at Large of the American Mental Health Counselors Association; and Dr. Arthur Evans, Jr., Commissioner of Philadelphia's Department of Behavioral Health and Intellectual DisAbility Services. I thank you all for being with us this morning and giving us so much of your time.

[The prepared statement of Mr. Murphy follows:]

PREPARED STATEMENT OF HON. TIM MURPHY

Right after the December 14, 2012 elementary school shootings in Newtown, Connecticut, the Subcommittee on Oversight and Investigations began a review of federal programs and resources devoted to mental health and serious mental illness.

Recent events have shown the continuing importance of this inquiry, including the September 2013 Navy Yard shooting just a couple of miles from where we sit this morning, in Washington, D.C.

Other tragic cases, like Seung-Hui Cho, James Holmes, Jared Loughner, and Adam Lanza, all exhibited a record of untreated severe mental illness prior to their crimes. It is a reflection of the total dysfunction of our current mental health system that despite clear warning signs, these individuals failed to receive inpatient or outpatient treatment for their illnesses that might have averted these tragedies.

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Part of the problem is that our laws on involuntary commitment are in dire need of modernization—it is simply unreasonable, if not a danger to public safety, that our current system often waits until an individual is on the brink of harming himself or others, or has already done so, before any action can be taken. The scarcity of effective inpatient or outpatient treatment options in the community, as illustrated by the premature release of Gus Deeds, son of Virginia senator Creigh Deeds, from emergency custody because of the lack of psychiatric beds, is also to blame. A sad ending that in our heart we cannot begin to imagine a parent's grief when told there is no place for your son to get help.

Nationwide, we face an alarming shortage in inpatient psychiatric beds that, if not addressed, will result in more tragic outcomes. This is part of the long-term legacy of deinstitutionalization, the emptying out of state psychiatric hospitals resulting from the financial burden for community-based care being shifted from the state to the federal government. With deinstitutionalization, the number of available inpatient psychiatric beds has fallen considerably. On the whole, the number of beds has decreased from 559,000 in the 1950s to just 43,000 today. We needed to close those old hospitals that had become asylums, lock-ups, and dumping grounds.

But where did all the patients go? They were supposed to be in community treatment—on the road to recovery—but for many that did not happen.

The result is that individuals with serious mental illness who are unable to obtain treatment through ordinary means are now homeless or entangled in the criminal justice system, including being locked up in jails and prisons.

Right now, the country's three largest jail systems—in Cook County, Illinois; Los Angeles County; and New York City—have more than 11,000 prisoners receiving treatment on any given day and are, in fact, the largest mental health treatment facilities in the country. These jails are many times larger than the largest state psychiatric hospitals.

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What can we do earlier in people's lives to get them evidence-based treatment, community support, and on the road to recovery not recidivism?

Where is the humanity in saying there are no beds to treat a person suffering from schizophrenia, delusions, and aggression so we will sedate you and restrain you to an ER bed for days?

This morning, to provide some perspective on the far-reaching implications of the current psychiatric bed shortage and to hear some creative approaches to address it, we'll be receiving testimony from individuals with a wealth of experience across the full range of public services consumed by the seriously mentally ill. These include:

- Lisa Ashley, the mother of a son with serious mental illness who has been boarded multiple times at the emergency department;
- Dr. Jeffrey Geller, a psychiatrist and co-author of a report on the trends and consequences of closing public psychiatric hospitals;
- Dr. Jon Mark Hirshon, an ER physician and Task Force Chair on a recent study of emergency care compiled by the American College of Emergency Physicians;
- Chief Mike Biasotti, Immediate Past President of the New York State Association of Chiefs of Police and parent of a daughter with serious mental illness;
- Sheriff Tom Dart, of the Cook County, IL Sheriff's Office, who oversees one of the largest single site county pre-detention facilities in the U.S.;
- The Honorable Steve Leifman, Associate Administrative Judge, Miami-Dade County Court, 11th Judicial Circuit of Florida;
- Gunther Stern, Executive Director of Georgetown Ministry Center, a shelter and clubhouse caring for Washington D.C.'s homeless;
- Hakeem Rahim, a mental health educator and advocate;
- LaMarr Edgerson, a clinical mental health counselor and Director at Large of the American Mental Health Counselors Association; and
- Dr. Arthur Evans, Jr., Commissioner of Philadelphia's Department of Behavioral Health and Intellectual DisAbility Services.

I thank them all for joining us this morning.

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Mr. MURPHY. I would now like to give the ranking member an opportunity to deliver brief remarks of her own. Ms. DeGette.

OPENING STATEMENT OF HON. DIANA DEGETTE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO

Ms. DEGETTE. Thank you very much, Mr. Chairman. I want to thank you for having this hearing and also for your continued leadership on the important topic of mental health. I want to thank all of the witnesses for appearing before us today. I think this sets a record as the biggest panel we have ever had in this subcommittee, and I am looking forward to hearing each one of your perspectives. It is rare we ever get so much knowledge and such a breadth gathered in one place.

Mr. Rahim, I am especially glad that you are here with us this morning. This is our fourth hearing in this subcommittee on mental health during this Congress, but this is the first time we have ever heard directly from somebody who can share his own personal history with mental illness and sit before us as a testament to the possibility of recovery. I know it takes a lot of courage to tell these personal stories in public, and I want to commend you for being here.

I also want to commend Ms. Ashley and Mr. Biasotti for being here today as parents because I have been approached by so many parents in my district who know that I am working on these issues, talking to me about the heartbreak of having young adults or teenagers who are dealing with these issues and what it is like as a family member. All of you can add really good perspective to this, and I want to thank you.

The question for this hearing, where have all the patients gone, is a very important one. Individuals with serious mental illnesses like bipolar disorder or schizophrenia are showing up in emergency rooms, encountering the criminal justice system and becoming homeless far too often. One reason why this problem is getting worse is because of budget cuts for mental health and addiction services at the State and local level. The American Mental Health Counselors Association reported that between 2009 and 2012, States have cut nearly \$5 billion in mental health services.

Mr. Chairman, I am concerned about the impact of these cuts, and I hope that we can address them today, and also as we continue our joint efforts to work towards comprehensive mental health legislation, how we can address these cuts because, to be honest, if there are no beds for folks to go to, then anything we can do is going to be useless, and so we are going to have to work with State and local governments to figure out how to fund the appropriate amount of beds that we need.

It is also important to address the issue of patients with mental illnesses showing up in the ER, which we all know is less effective and more expensive to receive treatment than other alternatives, but I do think if these folks do show up in the ER, there are ways to improve the way they are treated there.

But I also want to focus our attention on an even more important question: how can we keep people with serious mental illness out of the emergency room in the first place? When people show up in the ER, it means that they have reached a crisis point and that represents a broader failure of our mental health system in this country. Our goal should be preventing crises from arising in the first place by investing in approaches to identify the early signs and symptoms of mental illness and to make sure that patients have quality health insurance and can get timely and effective mental health treatment and support services, and I will bet you every single provider, parent and patient in this room would agree with what I just said.

I don't want to downplay the concerns about the lack of inpatient beds for patients who need them. Despite our best efforts, there still will be instances where more intensive interventions are needed. But I hope that we can agree that these should be exceedingly rare occurrences and that having more inpatient beds is only a partial solution. The benefits provided by the Mental Health Parity and Addiction Equity Act and the Affordable Care Act will help prevent these ER crises if implemented correctly. They will provide millions of Americans with access to quality, affordable health insurance that includes coverage for mental health services. We need to build from these laws to support the continuum of mental health services at all levels of government, and I must say, I was very proud that we were able to include mental health parity in the Affordable Care Act. This will be very important for patients.

We also need to remember that recovery, even for individuals living with serious mental illness, is possible, or certainly at least management. Mr. Rahim is proof that individuals with access to the right range of services not only can we greatly reduce the number of individuals in crisis winding up in prisons or emergency rooms but we can produce hardworking, contributing members of society as well. As well as your bill that you have introduced, Mr. Chairman, there is a lot of other legislation out there, and I know we intend to continue working together to try to have some kind of comprehensive legislation that will begin to address all of these issues.

Thank you so much, Mr. Chairman.

Mr. MURPHY. I thank the gentlelady for her comments, and yes, we will continue to work together.

I now recognize the gentlelady from North Carolina, Mrs. Ellmers, if you want to make an opening statement.

Mrs. ELLMERS. Thank you, Mr. Chairman. I just want to make a brief statement, especially due to the size of our panel, and I am very anxious to hear from all of you on these issues.

You know, I served as a nurse for 21 years before coming to Congress, and there is nothing that is more heartbreaking than when you see a situation of mental illness and a family who is struggling to deal with that. I just want to say thank you to all of you. I want to take that opportunity because you coming forward will help us to finally deal with the situation, and it is a multifaceted situation and we all have to come together. This is not a political one, this is not one that we can't reach across the aisle and work together on.

So thank you to all of you, and God bless all of you.

Mr. MURPHY. The gentlelady yields back. Anybody on this side want any more of the remaining time? If not, we will now recognize the ranking member of the full committee, Mr. Waxman, for an opening statement, 5 minutes.

OPENING STATEMENT OF HON. HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. WAXMAN. Thank you very much, Mr. Chairman.

Today's hearing addresses an important issue affecting treatment and outcomes for patients with mental illnesses. We will hear today that budget cuts and other factors have resulted in a lack of inpatient beds for intensive psychiatric treatment, meaning that patients with serious mental illness who show up to the emergency room at a crisis point are forced to wait far too long, for days at a time, for an inpatient psychiatric bed.

This is a growing problem, but it is not a new one. A decade ago, as ranking member of the Oversight Committee, I released a report finding that all too often, jails and juvenile detention facilities have had to provide care for individuals with mental illnesses. This report found that due to lack of available treatment, youth with serious mental disorders were placed in detention without any criminal charges pending against them. In other cases, youth who had been charged with crimes but who had served their time or were otherwise able to be released remained incarcerated for extended periods of time because no inpatient bed, residential placement or outpatient appointment was available. That investigation found that two-thirds of juvenile detention facilities were holding youth waiting for mental health treatment, and that in one 6-month period, nearly 15,000 incarcerated youth were waiting for mental health services.

Mr. Chairman, I share your desire to end these practices. That is why I supported the Affordable Care Act, which provides health insurance coverage, including coverage for mental illness, to millions of Americans, and that is why I have opposed Republican efforts to repeal this law and take this coverage away. It is also why I hope that this hearing does not ignore the elephant in the room: the impact on millions of Americans with mental illnesses of the failure by 24 States to expand their Medicaid programs under the Affordable Care Act.

Last month the American Mental Health Counselors Association released a new study titled "Dashed Hopes, Broken Promises, More Despair," and I would like to ask that this report be made part of the hearing record.

Mr. MURPHY. Without objection, yes, it will be included.

[The information appears at <http://docs.house.gov/meetings/if/if02/20140326/101980/hrg-113-if02-20140326-sd004.pdf>.]

Mr. WAXMAN. Dr. Edgerson is here today to testify on behalf of the organization, and I appreciate him joining us.

The report found that the failure by states to expand their Medicaid programs is causing nearly four million people who are in serious psychological distress or have a serious mental illness or substance disorder to go without health insurance. That is four million

Americans in need who are left without coverage, largely because of Republican governors' ideological obsession with rejecting everything associated with the Affordable Care Act.

Mr. Chairman, this includes over 200,000 people with mental illnesses in your home State of Pennsylvania.

The report described the impact of this lack of coverage, finding that "The lack of health insurance coverage keeps people with mental illness from obtaining needed services and treatments and follow-up care with the goal of achieving long-term recovery and quality of life."

This is a tragedy and a shame. If these four million Americans obtained coverage, they would receive better ongoing treatment and care, and they would be less likely to end up in a hospital emergency room, or worse, a prison, with a mental health crisis.

Mr. Chairman, I know you want to help individuals with mental illnesses. We have both introduced mental health legislation, and I hope that as we move forward, we can find common ground with these bills.

But the biggest and easiest step we can take to improve care for those with serious mental illnesses is to make sure they have health insurance. The Medicaid expansion is a good deal for the states, and it is desperately needed by millions of Americans. This committee should be working together to make sure that regardless of where they live, Americans in all 50 states can obtain this coverage.

I yield back the balance of my time.

Mr. MURPHY. The gentleman yields back. Thank you.

I also have a letter from the National Association of Psychiatric Health Systems, also commenting on this topic today of psychiatric beds, and so I ask without objection to include that in the record as well.

[The information appears at the conclusion of the hearing.]

Mr. MURPHY. I have already introduced all of our witnesses today, so I am now going to swear you in. So you are aware, the committee is holding an investigative hearing, and we have the practice of taking testimony under oath. Do any of you object to taking an oath? All right. The Chair then advises you that under the rules of the House and the rules of the committee, you are entitled to be advised by counsel. Do any of you desire to be advised by counsel during your testimony today? It shouldn't be an issue. Thank you. In that case, if you would please rise and raise your right hand, and I will swear you in.

[Witnesses sworn.]

Mr. MURPHY. You may now sit down, and you are under oath and subject to the penalties set forth in Title XVIII, section 1001 of the United States Code. We will now recognize each of you to give a 5-minute opening statement.

I recognize first Ms. Ashley. Make sure your microphone is on and it is pulled close to you. Thank you.

TESTIMONY OF LISA ASHLEY, PARENT OF A SON WITH SERIOUS MENTAL ILLNESS, SACRAMENTO, CALIFORNIA; JEFFREY L. GELLER, M.D., M.P.H., PROFESSOR OF PSYCHIATRY AND DIRECTOR OF PUBLIC SECTOR PSYCHIATRY, UNIVERSITY OF MASSACHUSETTS MEDICAL SCHOOL, WORCESTER, MASSACHUSETTS; JON M. HIRSHON, M.D., M.P.H., PH.D., FACEP, TASK FORCE CHAIR, 2014 AMERICAN COLLEGE OF EMERGENCY PHYSICIANS NATIONAL REPORT CARD ON EMERGENCY CARE, AND ASSOCIATE PROFESSOR, DEPARTMENT OF EMERGENCY MEDICINE, UNIVERSITY OF MARYLAND SCHOOL OF MEDICINE, BALTIMORE, MARYLAND; MICHAEL C. BIASOTTI, CHIEF OF POLICE AND IMMEDIATE PAST PRESIDENT OF NEW YORK STATE ASSOCIATION OF CHIEFS OF POLICE, AND PARENT OF A DAUGHTER WITH SERIOUS MENTAL ILLNESS, NEW WINDSOR, NEW YORK; THOMAS J. DART, SHERIFF, COOK COUNTY SHERIFF'S OFFICE, CHICAGO, ILLINOIS; STEVE LEIFMAN, ASSOCIATE ADMINISTRATIVE JUDGE, MIAMI-DADE COUNTY COURT, ELEVENTH JUDICIAL CIRCUIT OF FLORIDA, MIAMI, FLORIDA; GUNTHER STERN, EXECUTIVE DIRECTOR, GEORGETOWN MINISTRY CENTER, WASHINGTON, D.C.; HAKEEM RAHIM, ED.M., M.A., SPEAKER AND MENTAL HEALTH EDUCATOR AND ADVOCATE, HEMPSTEAD, NEW YORK; LAMARR D. EDGERSON, PSY.D., LMFT, NBCCH, CLINICAL MENTAL HEALTH COUNSELOR, DIRECTOR AT LARGE, AMERICAN MENTAL HEALTH COUNSELORS ASSOCIATION, FAMILY HARMONY, ALBUQUERQUE, NEW MEXICO; AND ARTHUR C. EVANS, JR., PH.D., COMMISSIONER, DEPARTMENT OF BEHAVIORAL HEALTH AND INTELLECTUAL DISABILITY SERVICES, UNIVERSITY OF PENNSYLVANIA, PHILADELPHIA, PENNSYLVANIA

TESTIMONY OF LISA ASHLEY

Ms. ASHLEY. Hello, and good morning, Mr. Chairman and members of the subcommittee. Thank you for inviting me here to tell my son's story with the emergency room department in my vicinity.

I am a Nurse Practitioner with a master's degree. I have been in pediatric practice for 38 years, but that is not why I am here today. I am here as a mother of a son who is now 27 and diagnosed with paranoid schizophrenia 2 years ago. It has been a long and difficult story which I share with many parents.

My son was about 20 or 21 years old when I knew something was wrong but it wasn't until he went homeless when he was in L.A. and went missing for 3 weeks that I knew for sure. Of course he saw nothing wrong. When I was finally able to locate him, I brought him back to Sacramento. He was delusional, thinking the FBI was watching him, there were satellites in the sky monitoring his thoughts, having auditory hallucinations, could not have a conversation, laughing to himself, and not caring for his hygiene. Prior to this, my son was extremely bright, received 740 out of 800 on his math SATs, and was accepted to seven universities for mechanical engineering. His bizarre behavior went on for months but he refused to see a psychiatrist. He was bonded to his primary medical provider, who saw him several times trying to get him on a hold. I felt helpless and extremely frustrated. Even calling the po-

lice did not help because they did not feel that he was a harm to himself or others.

I am specifically going to tell a story regarding his hospital emergency department stays three times over a 2-year period. Each time, I struggled with pain and anguish to see my beautiful son taken into custody, especially for the first time, because he didn't know how sick he was and how very confused as to why he could not go home with me, and I cried my heart out.

The first time was in May 2012. He had been sick over a year before I was able to get him some help. His first time in the emergency room was approximately 12 hours. I couldn't believe they had to hold him there that long, not knowing there was a shortage of psych beds in the county. He was then transferred to a psych facility locally and remained 2 weeks, just as long as my insurance would allow him. Although it was very difficult to have my son hospitalized, I know he was in good hands and it relieved some of my anxiety, but still, it was nothing like I had ever been through and having to trust a system that was so foreign to you and difficult, I worried every minute.

The second time was not quite as smooth. In January of 2013, my son asked voluntarily to be taken to the hospital because his head felt like it was on fire. He was anxious and very distressed. I dropped everything, knowing that he was asking to go, he must have felt pretty bad. I brought him to the same emergency room that morning, we reached the triage nurse. I identified myself as an employee and a nurse practitioner. I explained my son was a paranoid schizophrenic and he was in psychosis. I tried to remain calm as the triage nurses took his blood pressure and temperature and then assigned him to a gurney in the hallway with at least eight other patients, which included children, all waiting to be seen by a doctor. It was not long before my son started to get agitated and wanting to leave. The R.N. called the social worker to help intervene. She could not quiet him down. As he tried to approach the exit, the emergency room policeman tried to stop him by holding him back. His behavior escalated. My son was screaming at him not to touch him. When schizophrenics are in psychosis, they do not want to be touched. In front of all the children and adults waiting in the hallway, the police officer wrestled him to the ground and handcuffed him.

I tell you this because I brought him to the hospital for medical treatment, not for police handcuffing him, and their intervention escalating his psychosis made it worse. If he had been able to go to some kind of psych facility, he would have gotten medical attention rather than police detention. Doctors would have known how to deal with him, calm him down, isolate him from others. The emergency room is not a quiet place and they are not trained to deal with psychiatric illnesses and certainly not serious mental illness.

They then placed him on a gurney and put him in four-point restraints and then medicated him. He was there on a Friday morning the whole day, all day Saturday, all day Sunday and all day Monday afternoon because they could not find a psych bed anywhere. He stayed in a room tied to his bed for four days, heavily medicated. Seeing him helpless tied to a bed for days was like a

nightmare. This was my son, and I was helpless except to keep him company and try to reassure him things would be all right. I was angry they couldn't find him a place. Does it really take that long to find a psych bed?

Finally, on Monday, I was told there was an opening at a hospital in San Francisco, which is 100 miles east of Sacramento. They finally took him there later that day. I was unable to be involved in his care because he was so far away except for weekends. It was very frustrating. I didn't understand why he needed to go so far away from his family member, who cared for him and loved him.

By the way, if I hadn't had private insurance, he never would have gone to that hospital because they don't accept public monies, so because I had private insurance, they took him. Otherwise, who knows? He might still be there.

The third time was in November. Again, his head was burning and voices were screaming at him. I took him back to the hospital. They put him on a gurney in the hallway again. I was able to be proactive and talk with other providers prior to this, and set up a plan so that the second intervention would never, ever happen to him again. I was able to make some phone calls, and after two days get him into a local psych facility, where he stayed another 3 days.

My son is fairly stable since that time in November. He has not required any additional hospitalization but he attends regular psychiatric visits and takes his medications regularly, and I pray every day that he continues to stay out of the emergency room because there are no other alternatives for him.

Thank you.

[The prepared statement of Ms. Ashley follows:]

March 26, 2014

Testimony Before The Committee On Energy and Commerce

By Lisa M. Ashley

Good Morning Mr. Chairman and members of the subcommittee. Thank you for inviting me here today to tell of my son's experience with Emergency Department (ED)

I am a Pediatric Nurse Practitioner with a Master's degree in pediatrics and have practiced for 38 years.

But I am not here to testify in that capacity. I am here as a mother of an adult son who was diagnosed with Paranoid Schizophrenia 2 years ago. It is a long difficult and painful story like most.

My son was about 20-21 yrs. old when I knew something was wrong but it wasn't until he went homeless in LA and went missing for 3 weeks that I knew for sure. Of course he saw nothing wrong. When I was finally able to locate him, I brought him back to Sacramento. He was delusional, thinking the FBI was watching him, there were satellites in the sky that were monitoring his thoughts, having auditory hallucinations, could not hold a conversation, laughing to himself, not bathing or changing his clothes. Prior to this my son was extremely bright, received 740 out of 800 on his math SAT, was accepted to 7 Universities for mechanical engineering. His bizarre behavior went on for months. He refused to see a psychiatrist. He would see his primary medical doctor who was instrumental in having him 5150 two years ago. I felt helpless and extremely frustrated. Even calling the police did not help since they did not believe he was harm to himself or others.

I am specifically going to tell his story regarding his stay in hospital emergency departments (ED), three times over a two year period. (We have no Psychiatric Hospital ED and the Sacramento County closed the Crisis Unit 3 years ago.) Each time I struggled with such pain and anguish, to see my beautiful son taken into

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custody and especially the first time, because he didn't know how sick he was and was very confused as to why he could not go home with me. I cried my heart out.

The first time was in May of 2012. He had been sick for almost over a year before I was able to get him evaluated. I told him I was taking him to the hospital to have some blood test done that his doctor ordered. With the help of his primary medical provider and his colleague who was the psychiatric ED physician, we were able to get my son admitted to the ED quickly, placed in a room and placed on a 72 hour hold. His stay the first time in the ED was for approximately 12 hours. I couldn't believe they had to hold him there for that long, not knowing that there was a shortage of psych beds in the County. He was then transferred to a local psych facility and remained 2 weeks, just as long as my insurance would allow. Although it was very difficult for me to have my son hospitalized, knowing he was in good hands relieved some of my anxiety. But still it was nothing like I had ever been through and having to trust a system that is so foreign to you is difficult as well. I worried every minute.

The second time was not quite as smooth. In January 2013, my son had asked voluntarily to be taken to the hospital because "he felt his head was on fire", he was very anxious and distressed. I dropped everything, knowing that if he was asking to go, he must have felt pretty bad. I brought him to the same ED that morning. When we reached the triage nurse, I identified myself as an employee and a nurse practitioner. I explained my son was a paranoid schizophrenic and was in psychosis. I tried to remain calm as the triage nurses took his blood pressure and temp and then assigned him to a gurney in the hallway with at least 8 other patients which included children. All waiting to be seen by a doctor. It was not long before my son starting to get agitated and wanting to leave. The RN called the social worker to help intervene. She could not quiet him down. As he tried to approach the exit, an ED policeman tried to stop him by holding him back. His behavior then escalated. My son was screaming at him not to touch him (when schizophrenics are in psychosis they do not want to be touched). In front of all the children and adults waiting in the hallway, the police officer wrestled him to the ground and handcuffed him. I tell you this because I brought him to the hospital for medical treatment not for police handcuffing him, and their

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intervention escalated his psychosis and made it worse. If he had been able to go to some kind of psych facility, he would of gotten him medical attention rather than police attention. Doctors would have known how to deal with him, calm him down and isolated him from others. The ED is not a quiet place and they are more trained to deal with physical illness and not mental illness.

They then placed him on a gurny, put him in 4 point restraints and then medicated him. He was screaming obscenities at me telling me this was my entire fault. I was taken to another part of the ED with social worker to help calm me down. To see all this happen to someone you love, especially your own child is devastating and heart wrenching. Later the officer came by and just wanted me to know he was not going to press charges. That was not helpful and it made me even more upset that he even considered pressing charges.

My son was admitted on Friday morning and was in the ED, that whole day, all day Saturday, all day Sunday until late Monday afternoon because they could not find an open psych bed anywhere. He stayed in a room, tied to his bed for those 4 days and was heavily medicated. Seeing him helpless tied to a bed for days was like a nightmare. This was my son, and I was helpless except to keep him company and to try to reassure him that things would be alright. I was angry that they could not place him somewhere. I wondered, "Really, does it take that long to find a psych bed?" Finally on Monday, I was told there was an opening at a hospital in San Francisco, 100 miles East of Sacramento. They took him later that day by ambulance. He stayed there another 2 weeks and because I work full time I was unable to see him except on the weekend and speak with him on the phone daily. I could not be a part of his treatment because he was so far away and that was extremely frustrating. Why did he need to go away so far from the family member who cared and loved him? By the way if I did not have him on my insurance plan he would have waited even longer in the ED because this facility did not take Medi- Cal (Medicaid).

I complained to the hospital about how he was treated in the ED. The head Physician of the ED agreed with me and said that if they had been able to place

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him in a quiet room, given him some additional antipsychotics, he may have not even needed to be hospitalized at all. He said they would make some policy changes so this did not happen again. He said people don't recognize the pain in mental illness is just as bad as the pain with a gun wound, you just don't see it.

The third time he was hospitalized was last November 2013. Once again "his head was burning and the voices were screaming at him". I took him back to the hospital ED, told the Triage nurse he was a Paranoid Schizophrenic having a psychotic episode and once again they placed him on a gurney in the hallway. Fortunately it was quiet with no others but staff there. I was very upset; I was silly enough to think they really did change the policy. I insisted that they place him a quiet room and not leave him in the hallway like before, but I was told there were no rooms available and we would have to wait. Once again after a while he wanted to leave, this time 4 officers surrounded him but were able to talk him into staying and after several hours they then placed him in a room, tied him to the bed, sedated him. He was there for the entire day and most of the next. The only reason he was there for only 2 days that time is because in the months previous, I had made contact with a staff member at one of the local psych hospitals and, was able to call them and they made arrangements to transfer him there later that second day. He stayed another 3 days in the psych hospital. I was finally getting to know the system, but every time he becomes psychotic and I know I have no alternative but to bring him to the ED, knowing he will have a long stay, it upsets me, it shouldn't be so hard to get the right care you need at the right time in the right place.

Because of these experiences, my son has told me he will never again go willingly to the ED. I only hope and pray that we will not need to return.

My son has been fairly stable since November not requiring any additional hospitalizations but attends regular psychiatrist visits and takes his medications regularly. I pray every day that he continues to stay in treatment.

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Additionally, I attended a recent conference at this facility where they presented information about the effects on the ED as a result of the County closing beds (50 from 100 beds plus closure of the Crisis Unit). The staff stated that there was a 5 fold increase in the number of mentally ill patients admitted into the ED (1.3 to 4.4 patients per day) in 2012. In 2013 there were approximately 6.5 patients admitted per day and placed on holds with an average wait time of 40 hours before being placed in a psychiatric hospital somewhere in the State.

Thank for the opportunity to tell our story.

Mr. MURPHY. Thank you, Ms. Ashley. I appreciate your moving testimony.

I forgot to mention at the time to keep your comments to 5 minutes, so if you hear my gavel tapping, that is why.

Doctor, you are next.

TESTIMONY OF JEFFREY L. GELLER

Dr. GELLER. Mr. Chairman, Representatives, ladies and gentlemen, good morning. I am Dr. Jeffrey Geller, a board-certified psychiatrist, currently Professor of Psychiatry at the University of Massachusetts Medical School, Medical Director of the Worcester Recovery Center and Hospital, and Staff Psychiatrist at the Carson Community Mental Health Center.

I have consulted public mental health systems and State hospitals in one-half of the States in the United States, the District of Columbia and Puerto Rico. I am the author of 250 publications in the professional literature, and the book, "Women of the Asylum." I serve on many professional boards but I come here today representing only my own experience taking care of patients with serious mental illness for 40 years.

Just yesterday, there were 22 psychiatric patients in a general hospital emergency room in a city of 150,000 not far from here waiting for disposition. Why? What is to be done?

On May 3, 1854, President Franklin Pierce vetoed a bill that would have made the Federal Government responsible for America's population with serious mental illness. His veto message includes the following beliefs of his: State hospitals or public psychiatric hospitals are meritorious institutions doing good. They fulfill a historic role belonging to the States, meeting the needs of a population outside the purview of the Federal Government and susceptible to becoming the responsibility of the Federal Government if the Federal Government provided any opportunity to the States to shift the burden.

The Federal Government left the care of the serious mentally ill to the states until Congress passed and President Kennedy signed the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963. From then until now, federal actions such as Medicaid, Medicare, the IMD exclusion and many others have resulted in the unintended consequences of massive proportions, not the least of which is deinstitutionalization. We created the perfect formula for the current debacle: an expanding array of fiscal incentives for States to move people out of state hospitals, inadequate resources to meet the needs of State residents with serious mental illness in the community, no beds in State hospitals to meet the needs of former State hospital patients, who did not find the community the panacea promised by the Supreme Court and were dangerous outside of hospitals, no beds to meet the needs of new cases of serious mental illness requiring a hospital level of care, and a public more willing to build jails and prisons than hospitals because they found no solace in a state system they saw as pushing ill-prepared folks with mental illness into their neighborhoods.

How did this lead to individuals waiting in hospital emergency departments, or EDs, for weeks, sometimes a month? Pick any

State. There are no available beds in the State's public psychiatric hospitals because there are too few beds. A patient on the psychiatric unit in a general hospital has been approved for transfer to the State hospital but cannot be transferred because there is no available bed. Thus, the general hospital psychiatric unit is populated by some patients who are stuck there awaiting state hospital transfer. An individual is brought to the general hospital's emergency department by police, family, ambulance, or comes on her own. The individual was assessed and determined to need hospitalization. The individual cannot be admitted to the psychiatric unit in the same hospital as the emergency department because there are no beds there.

What happens next is, a hospital emergency department staff or a member of a contracted crisis team starts a bed search. A bed search means calling every hospital in the State seeking a bed. Frequently, the bed search is fruitless. There are no beds available anywhere because all the hospitals are in the same situation as the psychiatric unit in the hospital the worker is calling from. So the individual remains in the emergency department waiting for an available bed. The days waiting benefit no one. The ED becomes overcrowded. The patient is a patient in name only. He is not getting treatment except that he is receiving food, a bed or gurney, and maybe some medication. He might as well be waiting on a bench in a train station. Or the individual is simply released from the emergency department because there is no place else for her to go. The threshold for holding somebody in the emergency department awaiting admission keeps creeping up. Many released folks are picked up by the police, processed through the courts, sent to the State hospital for a forensic evaluation, further decreasing available beds to the person awaiting a bed in the emergency department.

Congress can enact measures to ameliorate the problems of boarders in emergency departments. These include: provide States with opportunities to obtain IMD exclusion waivers with maintenance of effort; make SSI and SSDI payments to eligible individuals independent of where they reside and require their contribution for room and board to be the same in all locations including jails and prisons; individuals keep their Medicaid and Medicare in all settings. Improve the federal grant process for research into prevention and early intervention; provide grants to States to create or expand crisis intervention teams so that such a program is available in every city and town; set fair and reasonable Medicaid payment rates for psychiatric services at community mental health centers and Federally Qualified Health Centers; incentivize States to actually use the assisted outpatient treatment statutes they have; define Medicaid and Medicare payments to clubhouses in ways that do not destroy the mission of clubhouses; incentivize States to establish mental health courts.

Mr. Chairman, Representatives, it is time the Federal Government took explicit action through bipartisan, bicameral efforts to remedy the calamitous state of the public care and treatment of persons with serious mental illness in the United States today.

Thank you.

[The prepared statement of Dr. Geller follows:]

U.S. House of Representatives
Committee on Energy and Commerce
Oversight and Investigation Subcommittee
"Where Have All the Patients Gone: Examining the Psychiatric Bed Shortage"
March 26, 2014
Written testimony of Jeffrey Geller, MD, MPH

Credentials

Jeffrey Geller, MD, MPH is a board certified psychiatrist who currently is a professor of Psychiatry at the University of Massachusetts, Medical Director of the Worcester Recovery Center and Hospital, and staff psychiatrist at the Carson Community Mental Health Center. I have consulted to public mental health systems and state hospitals in one-half the states, the District of Columbia and Puerto Rico. I am the author of about 250 publications in the professional literature and of the book, *Women of the Asylum*. I serve on boards of the American Psychiatric Association, the American Association of Community Psychiatrists, Clubhouse International, the Treatment Advocacy Center, and the World Federation for Mental Health. Despite these affiliations, I come before you today representing only my experience taking care of persons with serious mental illness for 40 years.

Testimony

Background: If we are today to understand why we have persons with serious mental illness stalled in hospital emergency departments with nowhere to go for hours to weeks, we need to start with the **Land-Grant Bill For Indigent Insane Persons**, passed by both houses of Congress at the urging of Dorothea Dix in 1854. On May third of that year, President Franklin Pierce vetoed this bill—the first veto of his presidency.

In his Veto Message, President Pierce opined, "It is clear that public charities within the States can be efficiently administered only by their authority." In the matter of those persons with inadequate resources for psychiatric treatment, Pierce stated, "if the several States, many of which have **already laid the foundation of munificent establishments of local beneficence [i.e., state public psychiatric hospitals]**, and nearly all of which are proceeding to establish them, shall be led to suppose, as, should this bill become a law, they will be, that Congress is to make provision for such objects, the fountains of charity will be dried up at home, and the several States, instead of bestowing their own means on the social wants of their own people, may themselves, through the strong temptation which appeals to states as to individuals, **become humble supplicants for the bounty of the Federal Government, reversing their true relations to this Union.**

Thus by the mid nineteenth century, the President of the United States believed public psychiatric hospitals were

- meritorious institutions doing good
- fulfilling a historic role belonging to the states
- meeting the needs of a population outside the purview of the federal government
- susceptible to becoming the responsibility of the federal government if the federal government provided any opportunity to the states to shift the burden

If you remember nothing else about Franklin Pierce, remember that his prophetic statement of 1854 turned out to be exactly correct.

We can jump ahead about 110 years, as the federal government remained steadfast in its position and the states took on the ever expanding costs of caring for persons with serious mental illness and related conditions. By the mid 1950's every other hospital bed—that's 50% of all hospital beds of any kind in the USA—were occupied by persons who were in those beds due to their mental illness. In the USA, we had state hospitals with censuses at high as 16,000 – 18,000 patients.

In the mid 1950's, the modern era of psychopharmacology was born. First at Rockland County Psychiatric Hospital in New York State, then throughout New York State with the support of Governor Averill Harriman, and then across the USA, reserpine and then chlorpromazine were able to effectively treat the symptoms of schizophrenia sufficiently enough for people to be discharged in large numbers from state hospitals. These medications, along with shocking exposés that were fueling the exodus from state hospitals for a decade by then, and other forces such as advocacy, created, what in retrospect, was labelled "deinstitutionalization." Deinstitutionalization was not initiated as a considered policy; it was an accident of history.

With people emerging from state hospitals, some of whom had not cared for themselves for years, decades, or more than half a century in some cases, there needed to be a system of care and a workforce to meet these individuals' needs.

On October 31, 1963, President John Kennedy signed the last piece of major legislation he was ever to sign, Public Law 88-164, the "**Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963**". With this act, Kennedy did what Pierce had not done: He put the federal government in the role of being responsible for some part of the care

and treatment of persons with mental illness. The bill called for the construction of community mental health centers pursuant to state plans with later modifications of the bill specifying 2000 community mental health centers by 1980, and then one per 100,000 population holding steady at that rate.

But, as Senator Daniel Patrick Moynihan, who had worked with Kennedy on this project, said in his Senate Finance Committee hearing in 1994 (one I worked as a Robert Wood Johnson Health Policy Fellow in Senator Tom Daschle's office), "we built about 400 and then we forgot we set out to do this" (p.2). Moynihan went on to say, "To make great changes casually and not pay rigorous attention to what follows is to invite large disturbances." (p3)

The late Senator Paul Wellstone testified at that hearing. Senator Wellstone lamented, "Deinstitutionalization depended on the premise that the community and State systems would be well integrated and well-funded and it raised all sorts of expectations. It did not happen." (p. 9)

What did happen?

With the enactment of Medicaid under the 1965 Amendments to the Social Security Act, states, for the first time, could use the formula for federal financial participation(FFP) for a population in mental institutions—in this case those 65 years of age or older. The FFP is the part of the bill the federal government will pay and ranges from 50% to 87% based on the per capita income of the state's population.

Other populations were not included at that time because Congress again voiced its intention of leaving the care and treatment of those in psychiatric (mental) hospitals as the responsibility of the states. Congress did, however, expand use of the federal financial participation formula to include services to those with mental illness in general hospitals.

The 1965 changes to what became the **IMD exclusion** opened the first door for the states to begin to shift costs for the care and treatment of mentally ill persons to the federal government. In a state hospital, the state generally bears 100 percent of the cost of care and treatment. In any facility that is eligible for Medicaid reimbursement, each state pays much less than 100 percent, according to the federal financial participation formula.

Simply put, the Federal Government would pay its share if the individual was in a facility specializes in providing psychiatric-psychological care and treatment and had 16 or fewer beds, or if there were more than 16 beds than more than 50 percent of all the patients-residents in the facility had to primarily require care for reasons other than a mental disease.

And the race was on.

The states had two fiscal goals in competing in the race for Medicaid dollars. The first was to transfer as many people as the state could from places where the states paid dollar for dollar for care and treatment, i.e., state hospitals, to places where states paid only a fraction of the

cost for care, i.e., community residences and general hospitals. The second was to do so as fast as possible because, for example, if Pennsylvania could do it faster than New York, than New York tax payers would subsidize Pennsylvania's translocation of patients since Pennsylvania's mentally ill poor would be using more federal dollars than New York's.

The states could not publically acknowledge they were moving persons with serious mental illness from one location to another to garner more federal dollars. They risked a public uproar. So the states attached their fiscal policy to the progressive thinking of the day. The states proclaimed they were interested in patients' autonomy and self-determination; they sought to treat patients in the most integrated setting; and they were interested in patients' recovery. If all these interests had cost the state more, rather than less, I believe they would not have been interested in any of them. Ironically, we were dismantling the state hospitals with the same rationale we had built them: Do what's right and save money.

But no one actually *knew* we saved healthcare dollars with the wholesale movement of patients from hospital to community. The best study ever done, by Weisbrod, found there is no cost difference and perhaps you get a little more for your money in the community. But the myth eclipsed the reality.

In the 1990's, the federal government did a few things that provided even greater **thrust to the movement of persons with mental illness out of state hospitals. The Americans with Disabilities Act of 1990** was used by advocates and the US Justice Department to require states

to expand any form of existing community services they provided to accommodate all individuals in state hospitals who needed that service, arguing that Title II—"no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity"—required this

On June 22, 1999, the United States Supreme Court held in *Olmstead v. L.C.* that unjustified segregation of persons with disabilities constitutes discrimination in violation of Title II of the Americans with Disabilities Act. The Court held that public entities must provide community-based services to persons with disabilities when (1) such services are appropriate; (2) the affected persons do not oppose community-based treatment; and (3) community-based services can be reasonably accommodated, taking into account the resources available to the public entity and the needs of others who are receiving disability services from the entity.

The Supreme Court explained that its holding "reflects two evident judgments." First, "institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable of or unworthy of participating in community life." Second, "confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment."

The U.S. Supreme Court, for its part, had little justification for its assumptions. The court never defined "can handle" or "can benefit"; never indicated how it came to conclude that time in a

state hospital said anything about unworthiness”; and never informed us how simply moving a person with serious mental illness from the hospital to the community would accrue to them “family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment.” And in thousands upon thousands of cases, it has not.

There were other federal initiatives in the 1990’s that further incentivized states to empty out their state hospitals. The Balanced Budget Act of 1997 created a progressive deduction in disproportionate-share payments to facilities classified as IMDs between fiscal years 1998 and 2003. Disproportionate-share requires states to make payments, using federal dollars, to hospitals serving a disproportionate percentage of Medicaid and low-income patients. Since specialty hospitals can qualify as disproportionate-share facilities, and state hospitals serve populations that meet criteria for disproportionate-share payments, states applied for these payments—that is, federal dollars—even though patients do not qualify for federal dollars through Medicaid. States were thus able to increase their overall receipt of federal dollars by including state hospitals in their disproportionate-share hospitals. When Congress cut into this loop hole, maintaining patients in state hospitals became even less attractive to the states.

Further, the federal government was offering states various ways to obtain Medicaid waivers (sec 1115 and sec 1915(b)) that expanded the types of hospitals that could be used as alternatives to state hospitals. One such hospital type was the free-standing private psychiatric hospital. Thus states had more beds to use as Medicaid-funded alternatives to its state hospital.

The states, for all the reasons explained above, were moving patients out of state hospitals with Herculean gusto, outstripping the resources in the community. The states needed dollars to fund its part of Medicaid for the former state hospital patients. What better source than the money used to operate its state hospitals.

And while the states did do this, they did not do it in an effective manner. First, the funds from the closed state hospitals followed rather than preceded the patients into the community, so there were always inadequate community funds. And second, the states did not use all the money from closed state hospitals for community-based services, but rather transferred some to the states' general funds, so there were always inadequate community funds.

We now have our formula for the current debacle: A progressively expanding array of fiscal incentives for states to move people out of state hospitals; inadequate resources to meet the needs of the states' residents with serious mental illness in the community; no beds in state hospitals to meet the needs of former hospital patients who did not find the community the panacea promised by Supreme Court and were dangerous or unable to care for themselves outside of hospitals; no beds to meet the needs of new cases of serious mental illness requiring hospital-level of care; and a public much more willing to build jails and prisons than hospitals at taxpayers' expense because they found no solace in a state system they saw as pushing ill-prepared folks with mental illness into their neighborhoods.

Problem: Here's the debacle.

Pick any state. There are no available beds in the state's public psychiatric hospitals in large measure because the state closed so many beds. There are about 40,000 state hospital beds in the USA, a rate of 13-14 beds per 100,000 population. A consensus of experts polled for a Treatment Advocacy Center report suggests that 50 public psychiatric beds per 100,000 population is a minimum number. Thus, over 80% of the 50 states had less than half the minimum number of state hospital beds needed. The effects of the actual shortage are exacerbated by the fact that about 50% of the states have no systematic way to determine where a vacant bed might be, should one even exist in their public hospitals.

In the designated state, a patient on the psychiatric unit in a general hospital has been approved for transfer to the state hospital, but cannot be transferred because there are no available beds. Thus, the general hospital psychiatric unit is populated by some patients who are "stuck" there awaiting state hospital transfer. An individual is brought to the general hospital's Emergency Department by police, family, or ambulance, or came on her own. The individual is assessed and determined to need an inpatient hospitalization. This individual cannot be admitted to the psychiatric unit located in the same hospital as the emergency department because there are no beds there.

What happens next is a hospital ED staff or a member of the contracted crisis team starts a "bed search". A bed search means calling every hospital in the state that accepts the individual's insurance seeking a bed. Frequently, the bed search is fruitless; there's no bed

available anywhere because all the other hospitals are in the same situation as is the psychiatric unit in the hospital the worker is calling from.

So, the individual remains in the ED waiting for an available bed. How long can he be waiting?

In the best case scenario, a few hours. In some of the least resourced areas, for a month.

Those days of waiting benefit no one. The ED becomes over-crowded. The patient is a "patient" in name only. He is not getting treatment. Except that he is receiving food, a bed or gurney, and maybe some medication, he might as well be waiting on a bench in a train station.

Individuals who might otherwise be hospitalized after an ED evaluation are simply released from the ED because there is no place else for them to go. The threshold for holding someone in the ED awaiting admission keeps creeping up.

Not everyone sits idly by. The police often respond to persons they believe are both mentally ill and violating the law with arrests rather than ED drop-offs since leaving the person they picked up at the ED often means he or she will quickly be back on the street. The arrested individual is arraigned and a question of his competency to stand trial is raised. He is sent to the state hospital for a forensic evaluation, taking a bed that might have been used for a patient transferred from the general hospital. Thus, the movement of psychiatric patients from general hospitals is further slowed, and consequently the movement from the ED to the general

hospital psychiatric bed is delayed. The ED staff, told yesterday that today was the day for the ED discharge, find out it's not. No expected vacancy materialized.

The Affordable Care Act (ACA) appears to have some unintended consequences that could very well exacerbate the conundrums of psychiatric patients stuck in ED's. **More Americans will be insured.** That means more individuals will have the financial means to get outpatient psychiatric care and treatment. This should mean less use of the ED. But, insurance does not necessarily translate into access. There are not enough providers of psychiatric services. This will mean the newly insured will not get the psychiatric treatment they now expect, driving them to seek that treatment in ED's. There will be more insured individuals needing psychiatric inpatient treatment, but no more psychiatric beds than before. More demand, no more beds, means longer waits, translates into more people with psychiatric illness boarding in general hospital ED's.

The ACA **integrates care for Medicare-Medicaid enrollees** (the "dually eligibles") in an effort to support improved quality and lower cost of care for individuals enrolled in both Medicaid and Medicare through both the elimination of the duplication of services and expanded access to needed care. Where before, these individuals could be admitted from an ED to a psychiatric bed, in some states the companies contracted to manage the care of the dually eligible are requiring prior approval for psychiatric admissions. This means further delays in the ED, and may mean no approval at all for some who would have previously been approved for admission. The ED will have a new group of psychiatric patients with nowhere to go.

The ACA is not the only source of ambiguities reigning terror in America's ED's.

Medicare will generally not pay for services rendered to a beneficiary who is in custody or incarcerated at the time the service was delivered (42 CFR 411). What does that mean in ED's when police bring in patients they wish to keep in custody? And some overzealous CMS staff has interpreted the regulations to empower Medicare to deny payment for services rendered to an individual who was *ever* in custody or incarcerated, not just those currently in custody or incarceration. This may well be yet another fact to be checked before an ED can make a disposition. More facts to check translates to more time.

The remedies. There are measures that Congress can enact to ameliorate the problem of borders in Emergency Departments.

- **Provide states with the opportunity to obtain IMD Exclusion waivers.**
 - Under such a waiver, states would get Medicaid reimbursement for treatment in public IMD's.
 - States for their part would have to have maintenance of funding levels for community services to prevent wholesale shifting of persons with serious mental illness into state hospitals.
 - The net effect would be an increase in state hospital beds without a decrease in community resources.
 - The American Psychiatric Association adopted a Position Statement in 2007.
 - States should be offered the opportunity to receive a Federal exemption from the IMD exclusion for state hospitals and all nonprofits over 16

beds....To participate in the exemption states must demonstrate a maintenance of effort (maintain its mental health and substance abuse expenditures (excluding medication costs) from all sources, e.g., states DMH, DPH, DMA, DMR, DOC, DSS, DYS, other) at a level no less than the state's average expenditure over the preceding five years.

- **Make SSI and SSDI payments to eligible individuals independent of where they reside, and require their contribution for room and board to be the same in all locations, including jails and prisons. Individuals keep their Medicaid and Medicare in all settings.**
 - This would eliminate the gyrations states and recipients go through to maximize their incoming dollars and minimize their expenditures, ignoring treatment needs and unnecessarily maintaining folks in the wrong locus of service. Why would a patient move to an apartment and pay rent when he can live rent free in the state hospital and use the "rent money" for all manner of other expenditures.
 - In nonhospital settings, e.g., jails, prisons, payments for psychiatric services would be paid through outpatient billings.
- **Improve the federal grant process for research into prevention and early intervention for mental illness and substance abuse.**
 - The most effective way to decrease overcrowding in ED's is to have fewer people in the community who need to use the ED for psychiatric services.

- Study the effectiveness of wellness programs for persons with serious mental illness.

- **Provide grants to states to create or expand Crisis Intervention Teams (CIT) programs so that such a program is available in every city and town.**
 - CIT is a local initiative designed to improve the cooperation among law enforcement; mental health providers; agencies; and individuals and families affected by mental illness when police are called upon to respond face-to-face in situations with complex issues relating to mental illness.
 - CIT is most commonly made up of volunteer officers from each Uniform Patrol Precinct.
 - The CIT Model is based on special trained officers to respond immediately to crisis calls, ongoing training of CIT officers, and the establishments of effective partnerships.

- **Set Medicaid payments for psychiatric services at CMHC's and FQHC's at rates that actually allow persons with serious mental illness to receive the treatment they need.**
 - Current rates require these outpatient settings to subsidize their psychiatrists with income generated by other practitioners, e.g., social workers, doing psychotherapy.
 - Psychiatrists are forced to see patients at 15 minute intervals which can mean scheduling six patients per hour to account for no-shows.

- **Incentivize states to actually use the Assisted Outpatient Treatment (AOT) statutes they have.**
 - AOT, also called outpatient commitment, is court-ordered treatment in the community (including medication) for individuals with severe mental illness who meet strict legal criteria as defined by the state. Violation of the court-ordered conditions can result in the individual being hospitalized for further treatment in some states.
 - Forty-five states permit the use of assisted outpatient treatment AOT.
 - AOT is often underutilized due to lack of funding.
 - AOT is often underutilized because those unfamiliar with AOT fail to understand the ways in which AOT can protect individual rights.

- **Define Medicaid and Medicare payments to Clubhouses in ways that do not destroy the mission of Clubhouses.**
 - Clubhouses are local community centers that provide members with opportunities to build long-term relationships that, in turn, support them in obtaining employment, education and housing.
 - Clubhouses members function within a work-ordered day during which members work to support the functioning of the Clubhouse; participation in consensus-based decision making regarding all important matters relating to the running of the Clubhouse; use opportunities to obtain paid employment in local jobs through Clubhouse-created Transitional Employment and then participate in Clubhouse-supported and independent jobs programs; avail themselves of

assistance in accessing community-based educational resources; receive assistance in securing and sustaining safe, decent and affordable housing; and enjoy evening/weekend social and recreational events sponsored by the Clubhouse.

- The nature of these activities does not fit the traditional Medicaid/Medicare reimbursement structure.
- **Incentivize states to establish Mental Health Courts.**
 - Mental Health Courts have their origin in the concept of specialty courts and the idea of therapeutic jurisprudence.
 - Mental Health Courts embrace a therapeutic rather than a punitive approach, but use the power of the court to enforce ordered treatment.
 - Mental Health Courts include identification of defendants for treatment and referral shortly after arrest, judicial supervision of structured community-based treatment, regular hearings to monitor treatment progress and compliance, and graduated sanctions for noncompliance with the MHC's ordered treatment.
 - Generally the defendant is given the choice: go to jail or participate in court-ordered treatment.

Conclusion: From the time the colony of Virginia opened America's first public psychiatric hospital in 1773 until now, responsibility for persons with serious mental illness has rested with the states. In more recent times, the federal government has become involved, but largely through the unintended consequences of federal policy. The federal government has issued

proclamations, such as President George W. Bush's New Freedom Commission Report on Mental Health, but these have been thought rather than action missives. It's time the federal government took explicit action--through bipartisan, bicameral efforts-- to remedy the calamitous state of the public care and treatment of persons with serious mental illness, one so well illustrated by individuals with serious mental illness languishing in hospital emergency departments, benefiting no one and interfering with emergency treatment of Americans in cities and towns coast to coast.

Mr. MURPHY. Thank you, Doctor.
Dr. Hirshon, you are recognized for 5 minutes.

TESTIMONY OF JON M. HIRSHON

Dr. HIRSHON. In emergency departments throughout the country, we emergency physicians expect the unexpected. This is what we are trained to do. Even so, there is one thing that we all know is happening: increasing demand by patients in need of acute psychiatric care.

Mr. Chairman and members of the subcommittee, thank you for this opportunity to testify today on behalf of the American College of Emergency Physicians. ACEP is the largest specialty organization in emergency medicine with more than 32,000 members in all 50 States and the District of Columbia.

My purpose today is to help you understand that we are in the midst of a national crisis, facing a dramatic increase in vulnerable mental health patients seeking emergent and urgent care. America's mental health services are experiencing increasing demand while concurrently receiving decreased funding, which drives psychiatric patients to the ED, or emergency department.

In 2000, psychiatric patients to the ED accounted for only 5.4 percent of all ED visits, but by 2007, that number had risen to 12.5 percent, well over a doubling of the number of psychiatric patients. Until more services and funding are made available to address this crisis, EDs will be the safety net for these patients. This is due in large part to the federal Emergency Medicine Treatment and Labor Act, EMTALA, which mandates medical screening evaluation and stabilization for anyone seeking care in an ED. Additionally, unlike many other health care settings, EDs are open 24 hours a day, 7 days a week every day of the year.

Emergency physicians do their best to provide care to patients with psychiatric conditions but the ED is not the ideal location for these services. ED crowding leads to delays in care and have been associated with poor clinical outcomes. For patients with mental health and/or substance abuse problems, prolonged ED stays are associated with increased risk of worsening symptoms. Without available appropriate inpatient resources for admitted patients, these patients wait or are boarded in the ED until an inpatient bed becomes available or an accepting facility can be found.

When the normal capacity of the ED is overwhelmed with boarded patients, there remains absolutely no room for surge capacity, which would be critical in the event of a manmade or natural disaster.

In a recent ACEP survey, 99 percent of emergency physicians reported admitting psychiatric patients daily while 80 percent said that they were boarding psychiatric patients in their EDs. Acutely ill psychiatric patients require more physician, more nurse and more hospital resources. ED staff spends more than three times as long looking for a psychiatric bed as they would for a non-psychiatric patient.

Other factors contribute to the extended ED boarding times for psychiatric patients including defensive medicine or threat of legal action, required preauthorization for inpatient services, medical clearance prior to psychiatric evaluation, substance abuse-related

issues, and inadequate outpatient services. As communities have seen, many of these issues are systems issues and beyond the control of the clinician. It is imperative that access to high-quality inpatient and community mental health care be a priority.

I go into further detail on suggested solutions in my written testimony but some important ones include full capacity protocols to improve the movement of admitted patients to inpatient floors, separate psychiatric ED and behavioral health annexes to help address urgent and emergent psychiatric needs, regionalized care and telemedicine to help efficiently and effectively address increasing demand, as well as the elimination of out-of-network insurance issues and community and State mental health buy-in.

Let me leave you with this: the increasing burden of mental illness in this country combined with a lack of resources to care for these individuals is a national crisis. Mass deinstitutionalization of mental health patients over the past few decades did not result in successful community integration of individuals needing psychiatric services, in part because the necessary services and funding were not put in place for adequate community support.

Systematic changes are needed in the way we care for these individuals with mental illness in this country. How we deal with these vulnerable individuals is an important measure of who we are as a society. Necessary resources must be made available for additional inpatient and outpatient treatment beds with the corresponding professional staff as well as for critically needed research. Otherwise mental health services will continue to deteriorate and these individuals, often our family members, will continue to be at risk for abuse and neglect, seeking care in EDs for lack of any other support.

I thank you for your attention to this alarming problem.

[The prepared statement of Dr. Hirshon follows:]

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Statement of

Jon Mark Hirshon, MD, MPH, PhD, FACEP, FAAEM, FACPM

University of Maryland School of Medicine
Baltimore, MD

On behalf of the
American College of Emergency Physicians (ACEP)

Before the
House Committee on Energy and Commerce
Subcommittee on Oversight and Investigations
U.S. House of Representatives

Hearing on

"Where Have All the Patients Gone? Examining the Psychiatric Bed Shortage."

Presented
March 26, 2014

I. Introduction

In the emergency department, doctors expect the unexpected. Even so, there's one thing they're starting to anticipate more and more: patients in need of psychiatric care.

Mr. Chairman and members of the subcommittee, my name is Jon Mark Hirshon, MD, MPH, FACEP, FAAEM, FACPM, and I would like to thank you for allowing me to testify today on behalf of the American College of Emergency Physicians (ACEP) to discuss the impact of providing psychiatric care in emergency departments across the nation. ACEP is the largest specialty organization in emergency medicine, with more than 32,000 members committed to improving the quality of emergency care through continuing education, research, and public education. ACEP has 53 chapters representing each state, as well as Puerto Rico and the District of Columbia and a Government Services Chapter representing emergency physicians employed by military branches and other government agencies.

In addition to my recent role as Task Force Chair for the development of ACEP's 2014 National Report Card on Emergency Care, I currently serve as an Associate Professor in the Department of Emergency Medicine; Department of Epidemiology and Public Health; and the National Study Center for Trauma and EMS at the University Of Maryland School Of Medicine.

In every community across the nation, America's emergency departments are experiencing increased demand and decreased funding. With the consolidation of hospitals, reductions in reimbursements and the shuttering of doors to many mental health facilities, there are fewer

places for patients to get help for mental health issues. More often than not, when mental health patients have emotional/psychological set-backs or medication issues, they may seek care at a psychiatric facility within the community only to find inadequate resources available. At that point, they often turn to the one part of the health care system that never closes and never turns anyone away – the emergency department (ED).

Emergency physicians are trained to treat the emergent medical and psychiatric conditions of anyone and everyone who arrives at their door, but more and more they find themselves busy caring for people with psychiatric issues like psychotic break-downs and suicidal tendencies. Where once they might have been stabilized and transferred to a psychiatric facility, they now end-up staying in the ED much longer than necessary, risking further harm to themselves and to others.

Emergency physicians are seeing more and more psychiatric patients because our "health care system" has failed to address the needs of patients with chronic psychiatric conditions, especially individuals with acute flairs of their chronic conditions. Until more services and funding are made available to address this crisis, EDs will be the safety net for those patients.

II. Reduction of Resources/Increased Utilization of Emergency Department Services

The 1960s movement to deinstitutionalize mental health patients and transition them to outpatient and community-based treatment centers saw a nationwide drop in inpatient and residential psychiatric beds for state and county mental health hospitals from approximately

400,000 in 1970 to 50,000 in 2006.^{i, ii, iii} While this was partially off-set by an increase of 50,000 private and general hospital psychiatric beds during the same timeframe, a large gap remains in the supply of psychiatric beds and facilities because of financial decisions and aggressive managed care utilization review. As noted in a 2009 Health Affairs study: "The decline in inpatient psychiatric services has been driven primarily by economics, not by advances in medical science or by changes in clinical need . . . the overriding motivation for deinstitutionalization was states' ability to shift the financial burden of care for the seriously mentally ill to federal sources."^{iv}

Community-based treatment centers for the mentally ill continue to see sharp declines in state funding. In fact, states cut more than \$1.6 billion (almost 10 percent) from their mental health spending from fiscal year 2009 to 2012. This decrease in funding has downsized or eliminated many mental health community services for children and adults. According to the National Alliance on Mental Illness (NAMI), approximately 60 percent of adults, and almost one-half of youth ages 8 to 15, with a mental illness received no mental health services in the previous year. Furthermore, NAMI states more than 61 million Americans experience mental illness in a given year with more than 13 million of them living with a serious mental illness, such as schizophrenia, major depression or bipolar disorder.

The shortage of inpatient psychiatric beds is a nationwide occurrence and this problem exists in all sites and settings – urban, suburban and rural geographic locations, as well as teaching and non-teaching hospitals alike. In January, ACEP released its 2014 National Report Card on Emergency Care. One of the data points we used to evaluate access to emergency care in each

state was how many psychiatric care beds there were per 100,000 people. The average of all the states was 26.1, with the fewest being 5.5 and the most being 52.7. This represents a decline in all categories compared to the same data collected five years ago in the 2009 iteration of that report (29.9 average, 8.2 fewest, and 54.8 most).

As the capacity of the mental health system continues to decline, patients turn to the ED for their unmet health needs. The ED has seen sharp growth in psychiatric visits, accounting for 12.5% of all ED visits in 2007, compared to 5.4% of all visits in 2000.^v ^{vi} This growth in psychiatric visits to the ED can be seen as an indirect measure of the failures of the outpatient mental health system.

The ED is often the last resort for patients with mental illness and is therefore used to attain basic, as well as acute, psychiatric care that includes medications, case management and therapy. The ED is regularly the primary resource for patients with a dual need for mental health and medical services. This is largely a factor of the federal Emergency Medical Treatment and Labor Act (EMTALA) mandate that requires emergency physicians to evaluate and stabilize anyone seeking care in a hospital ED.^{vii}

However, the focus of the ED is to provide treatment for medical, not psychiatric, conditions. Though emergency providers are trained, and EDs are prepared, to address patients with acute psychiatric needs, mental health care services are often inefficiently delivered in the ED, which leads to an overall decrease in ED capacity, shifting time, attention and resources away from other critical patients. In short, the destabilization of outpatient and inpatient psychiatric

resources has further exacerbated already overburdened emergency departments, which threatens the overall health care delivery system in this country.

III. Psychiatric Boarding in the Emergency Department

When the appropriate resources are unavailable to admit patients who require psychiatric services, these patients wait, or are "boarded," in the ED until an inpatient psychiatric bed becomes available or a facility that is willing to accept the patient transfer can be found. ED staffs spend more than three times as long looking for beds for psychiatric patients than for non-psychiatric patients.

According to a 2008 ACEP study on psychiatric and substance abuse, almost 80 percent of emergency physicians said psychiatric patients are boarded in their emergency department. Respondents to the study indicated that psychiatric boarding is a symptom of a greater mental health system crisis. Furthermore, 99 percent of emergency physicians reported admitting psychiatric patients daily. These psychiatric patients require more physician, nurse and hospital resources than other patients and thus diminish a doctor's ability to evaluate and treat other medical patients who are awaiting emergency care services.

There are several other factors that contribute to extended ED boarding times for psychiatric patients:

- Defensive medicine or the threat of legal action. A discharged patient who subsequently harms him/herself may take legal action against the ED and its personnel citing improper care or failure to admit.
- Required prior authorization from a health plan before a patient may be admitted as an inpatient.
- Psychiatric patients must first be cleared medically (per EMTALA requirements) before they can be screened for a psychiatric evaluation.
- Substance abuse can further complicate the admission process because patients cannot be sent to their inpatient bed until they are no longer intoxicated.
- Inadequate outpatient services, community resources and housing alternatives often leads to patients remaining in their inpatient beds for longer periods of time.

IV. Practice Improvements

There is still a great deal that we do not know about patients with mental illness. Addressing this information gap and making the case for tangible solutions is critical as our nation continues to grapple with implementation of new health reform laws. It is imperative that access and continuity of community mental health care be a priority as we move forward in the development of new policy.

Hosting a dialogue such as this one today is an important step in the right direction. As I previously discussed, *quantifying* the extent of psychiatric boarding is the first step in surmounting this critical problem. The U.S. Department of Health and Human Services (HHS)

has developed some valuable suggestions of practice improvements in that could prove useful in ameliorating the use of EDs as a primary source of psychiatric care.

Some of these solutions include:

- **Increased Staffing.** Given that boarding is, at times, caused by lack of inpatient hospital staff to care for the psychiatric patient rather than lack of inpatient psychiatric hospital beds, having additional staff would help alleviate this problem. This may include psychiatrists, psychologists, social workers, nurses, etc.
- **Better Case Management.** Ensuring that psychiatric patients receive care coordination regarding medication adherence and outpatient appointments may help prevent these patients from experiencing a relapse and potentially seeking care in the ED again.
- **Full-Capacity Protocol.** Some hospitals have instituted a policy that moves some boarded patients to other areas of the hospital, such as inpatient floors, when the ED is already operating at full capacity. These areas tend to be less chaotic and noisy and, therefore, are less likely to exacerbate a mental health crisis.
- **Improved Discharge Practices.** Improved throughput can include discharging patients before noon to improve the patient flow in the hospital and preparing for the busiest times of the day/week.
- **Improved Community Collaboration.** Better knowledge of outpatient alternatives among ED staff and strong collaboration between community crisis services and the ED are likely to lead to more appropriate discharge of patients to outpatient facilities, and a reduction in boarding.

- **Increased Outpatient Capacity/Community Alternatives.** Two specific community services that have shown promise as part of system-wide improvements of mental health services were crisis residential services and mobile crisis teams. Crisis residential settings could care for patients who do not need to be in a hospital setting, allowing the ED to see more acute medical patients. Mobile crisis, often referred to as diversion teams, provide crisis intervention and stabilization services to psychiatric patients in the community, preventing many patients from seeking care in the ED.
- **Separate Psychiatric ED/Behavioral Health Annex.** A separate psychiatric ED or behavioral health annex is a component of the psychiatric emergency services (PES) model in which psychiatric patients are placed in a separate ED/annex after medical clearance. This removes patients from the general ED, as well as increases the likelihood that they receive care from trained mental health professionals while boarding.
- **Increased Hospital Inpatient Capacity.** Additional psychiatric, inpatient beds would help to alleviate boarding for those patients who require hospital-level care.
- **Regionalization of Care.** The care of boarded patients could be improved by implementing standard processes across hospitals within the same region such as standard boarding procedures, as well as coordination across hospitals and at the state level regarding capacity issues.
- **Innovative Psychiatry (Tele-Psychiatry & Psychiatrists as Hospitalists).** Use of tele-medicine would allow psychiatrists to perform evaluations and screenings of psychiatric patients when they cannot be physically present in the ED. This may alleviate inappropriate inpatient admission, and thus, lead to reduced boarding.

- **Eliminate Out-of-Network Insurance Issues.** Hospitals that have available psychiatric beds are not always authorized to accept patients if these hospitals are not in the patients' insurance network. Eliminating the in-network requirement would increase available options for inpatient care.
- **Community/State Mental Health Buy-In.** State health departments and legislatures must be involved in reforming the existing system in order to properly implement community-wide solutions. Such involvement to improve mental health access and quality and reduce boarding would entail a fiscal commitment among partners at the community or state level. Federal resources could significantly help states and local communities meet these additional financial obligations.

VI. Conclusion

The prevalence of mental illnesses in this country, combined with a lack of resources to care for these individuals in the most appropriate setting, is a national crisis. Mass deinstitutionalization of mental health patients over the past few decades did not result in successful community integration of individuals needing psychiatric services because the necessary services and funding were not put in place for adequate community support. As a result, increasing numbers of chronically mentally ill individuals have no place to go for comprehensive treatment. Rather than being integrated into the community, this population has been supplanted into other facilities, such as nursing homes, jails and prisons, while a growing number routinely seek psychiatric care in the nation's emergency departments.

Emergency physicians do their best to provide care to patients with psychiatric conditions, but the ED is not the ideal location for these services. Poor clinical outcomes, evidenced as delays in care and increases in morbidity and mortality, have been directly associated with ED overcrowding. For patients with mental health and/or substance abuse issues, prolonged ED stays are associated with increased risk of symptom exacerbation or simply leaving the ED without being seen or treated. Furthermore, as the normal capacity of the ED is overwhelmed with boarded patients, it leaves absolutely no room for surge capacity, which would be critical in the event of a man-made or natural disaster.

Systemic changes are needed in the way individuals with mental illness are cared for in this country. Additional resources must be made available to conduct vitally needed research on this issue and to fund additional inpatient and outpatient treatment beds with the corresponding professional staff. Otherwise, mental health and emergency care services will continue to deteriorate.

ⁱ Tuttle GA. Report of the Council on Medical Service, American Medical Association: Access to psychiatric beds and impact on emergency medicine. CMS report 2-A-08. American Medical Association Web site. Available at: www.ama-assn.org/ama1/pub/upload/mm/372/a-08cms2.pdf.

ⁱⁱ Alakeson V, Pande N, Ludwig M. A plan to reduce emergency room “boarding” of psychiatric patients. *Health Aff.* 2010; 29:1637–1642.

ⁱⁱⁱ Stone A, Rogers D, Kruckenberg S, et al. Impact of the Mental Health Care Delivery System on California Emergency Departments. *West J Emerg Med.* 2012;13(1):51-56.

^{iv} Sharfstein S. Hospital Psychiatry For The Twenty-First Century. *Health Affairs.* May/June 2009. 685-688.

^v Pandya A, Larkin GL, Randles R, et al. Epidemiological trends in psychosis-related emergency department visits in the United States, 1992-2001. *Schizophr Res.* 2009;110:28-32.

^{vi} Owens PL, Mutter R, Stocks C. *Mental Health and Substances Abuse Related Emergency Department Visits Among Adults in 2007. HCUP Statistical Brief # 92*. Rockville, MD: Agency for Healthcare Research and Quality; 2010. Available at: <http://www.hcup-us.ahrq.gov/reports/statbriefs/sb92.pdf>.

^{vii} Department of Health & Human Services. Mental health and mental disorders. In: *Healthy People 2010: Understanding and Improving Health*. Washington, DC: United States Department of Health & Human Services; 2000:18.1–18.32.

Mr. MURPHY. Thank you, Doctor.
Chief Biasotti, you can pull that microphone right up next to you, please. Thank you.

TESTIMONY OF MICHAEL C. BIASOTTI

Chief BIASOTTI. Good morning, Chairman Murphy and Ms. DeGette. I am the immediate past President of the New York State Association of Chiefs of Police and Chief of Police in New Windsor, New York. I am in my 38th year of service.

My wife, Barbara, who is a psychologist, is here today with me. We have a daughter with schizophrenia who has been involuntarily hospitalized in excess of 20 times. Barbara and I met when she, like many moms, turned to the police for help when her, now our daughter became psychotic, disruptive and threatening. She was self-medicating, unemployed and deteriorating, despite my wife's heroic efforts to help her. Then she went into assisted outpatient treatment. It saved her life.

In 2011, while at the United States Naval Postgraduate School's Center for Homeland Defense and Security, I published a survey of over 2,400 senior law enforcement officers titled "Management of the Severely Mentally Ill and its Effects on Homeland Security." It found that the mentally ill consume a disproportionate percentage of law enforcement resources. Many commit low-level crimes. One hundred and sixty thousand attempt suicide, 3 million become crime victims, and 164,000 are homeless each year.

The survey essentially found that we have two mental health systems today, serving two mutually exclusive populations. Community programs serve those who seek and accept treatment. Those who refuse, or are too sick to seek voluntary treatment, become law enforcement responsibilities. Officers in the survey were frustrated that mental health officials seemed unwilling to recognize or take responsibility for this second more symptomatic group. Ignoring them puts patients, the public and police at risk and costs more than keeping care within the mental health system.

As an example, there are fewer than 100,000 mentally ill in psychiatric hospitals but over 300,000 in jails and prisons. The officers I surveyed pointed out the drain on resources it takes to investigate, arrest, fill out paperwork and participate in the trials of all of them. Add to that the sheriffs, district attorneys, judges, prisons, jails and corrections officers it takes to manage each of them and you see the scope of the problem.

Many more related incidents, like suicides, fights and nuisance calls take police time, but don't result in arrest or incarceration. Overly restrictive commitment standards and the shortage of hospital beds are major sources of frustration for officers. Hospitals are so overcrowded they often can't admit new patients and discharge many before they are completely stable. They become what we call round trippers or frequent flyers. One officer referred to it as a human catch and release program. Anyone who asks for help is generally not sick enough to be admitted, so involuntary admission, that is, being a danger to self or others, becomes the main pathway for treatment. Officers are called to defuse situations and then have to drive in some cases hours to transport individuals to hospitals and then wait hours in the emergency rooms, only to find

the hospital refuses admission because there are no beds or that the commitment standard is so restrictive. The only remaining solution for our officers is to arrest these people with serious mental illness for whatever minor violation exists, something that they are loathe to do to sick people who need medical help, not incarceration.

Finally, while everyone knows that everyday mental illness is not associated with violence, untreated serious mental illness clearly is. The officers in the survey deal with that reality every day. You in Congress dealt with it when Ronald Reagan and Gabrielle Giffords were shot; two guards in the Capitol building were killed, and the Navy Yard shooting happened. Representatives DeGette, Gardner and Griffith have experienced the worst of the worst in their States.

We have to stop pretending that violence is not associated with untreated serious mental illness. We have to stop pretending that everyone is well enough to volunteer for treatment and then self-direct their own care; some clearly are not.

As I wrote in the intro to the survey, police and sheriffs are being overwhelmed dealing with the unintended consequences of a policy change that in effect removed the daily care of our Nation's severely mentally ill population from the medical community and placed it with the criminal justice system. This policy change has caused a spike in the frequency of arrests of severely mentally ill persons, prisons, and jail populations as well as the homeless population and has become a major consumer of law enforcement resources nationwide.

If I could make one recommendation, it would be to prevent individuals from deteriorating to the point where law enforcement becomes involved. Return care and treatment of the most seriously ill back to the mental health system. Make the seriously mentally ill first in line for services rather than last. As a law enforcement officer and a father, I know that treatment before tragedy is a far better policy than treatment after tragedy.

Thank you so much.

[The prepared statement of Chief Biasotti follows:]

U.S House of Representatives Committee on Energy and Commerce
Subcommittee on Oversight and Investigations
"Where Have All the Patients Gone? Examining the Psychiatric Bed Shortage."
March 26, 2014

Testimony of Chief Michael C. Biasotti

Immediate Past President New York State Association of Chiefs of Police
Chief of Police New Windsor New York
Author: *Management of the Severely Mentally Ill and its Effect on Homeland Security*
Chief of Police, New Windsor, NY

Chairman Murphy and Ms. DeGette: I am the Immediate Past President of the New York State Association of Chiefs of Police, and Chief of Police, in New Windsor N.Y. My wife, Barbara, who is a psychologist, is here with me. We have a daughter with schizophrenia who has been involuntarily hospitalized more than 20 times. Barbara and I met when she, like many moms, turned to the police for help, when her, now our daughter became psychotic, disruptive and threatening. She was self-medicating, unemployed, and deteriorating despite my wife's heroic efforts to help her. Then she went into Assisted Outpatient Treatment. It saved her life.¹

In 2011, while at the U.S. Naval Postgraduate School's Center for Homeland Defense and Security, I published a survey of over 2400 senior law enforcement officers titled "*Management of the Severely Mentally Ill and its Effect on Homeland Security.*"² It found that the mentally ill consume a disproportionate percentage of law enforcement resources. Many commit low-level crimes.³ 160,000 attempt suicide⁴, 3 million become crime victims⁵, and 164,000 are homeless.⁶

The survey essentially found we have two mental health systems today, serving two mutually exclusive populations: Community programs serve those who seek and accept

treatment. Those who refuse, or are too sick to seek treatment voluntarily, become a law enforcement responsibility. Officers in the survey were frustrated that mental health officials seemed unwilling to recognize or take responsibility for this second more symptomatic group. Ignoring them puts patients, the public and police at risk and costs more than keeping care within the mental health system.

As an example, there are fewer than 100,000 mentally ill in psychiatric hospitals⁷ but over 300,000⁸ in jails and prisons. The officers I surveyed pointed out the drain on resources it takes to investigate, arrest, fill out paperwork and participate in the trials of all of them. Add to that the sheriffs, district attorneys, judges, prisons, jails and correction officers it takes to manage each of them and you see the scope of the problem.⁹ Many more related incidents, like suicides, fights and nuisance calls take police time, but don't result in arrest or incarceration.

Overly restrictive commitment standards and the shortage of hospital beds are major sources of frustration for officers. Hospitals are so overcrowded they often can't admit new patients and discharge many before they are stable. They become what we call 'round-trippers' or 'frequent flyers', one officer referred to it as a human "Catch and Release Program". Anyone who asks for help, is generally not sick enough to be admitted, so involuntary admission, that is, being a "danger to self or others" becomes the main pathway to treatment. Officers are called to defuse the situation and then have to drive in some cases hours to transport the individual to a hospital, wait hours in the ER, only to find the hospital refuses admission because there are no beds or the commitment standard is so restrictive. The only remaining solution for our officers

is to arrest people with serious mental illness for whatever minor violation exists, something we are loathe to do to sick people who need medical help, not incarceration.

Finally, while everyone knows your everyday mental illness is not associated with violence, untreated serious mental illness clearly is.¹⁰ The officers in the survey deal with that reality every day. You in Congress dealt with it when Ronald Reagan and Gabrielle Giffords were shot; two guards in the Capitol building were killed, and the Navy Yard shootings happened. Representatives DeGette, Gardner and Griffiths' have experienced the worst of the worst in their states.

We have to stop pretending that violence is not associated with untreated serious mental illness. We have to stop pretending that everyone is well enough to volunteer for treatment and self-direct their own care. Some clearly are not.

As I wrote in the intro to the survey, police and sheriffs are being overwhelmed "dealing with the unintended consequences of a policy change that in effect removed the daily care of our nation's severely mentally ill population from the medical community and placed it with the criminal justice system." ...This policy change has caused a spike in the frequency of arrests of severely mentally ill persons, prison and jail populations as well as the homeless population...(and) has become a major consumer of law enforcement resources nationwide."

If I could make one recommendation, it would be to prevent individuals from deteriorating to the point where law enforcement becomes involved. Return care and

treatment of the most seriously ill back to the mental health system. Make the seriously mentally ill first in line, rather than last. As a law enforcement officer and father, I know treatment before tragedy is a better policy than tragedy before treatment.

Thank you.

¹ A front page New York Times story July 30, 2013 on AOT, featured my wife and I. The story was timed to the release of a study, "The Cost of Assisted Outpatient Treatment: Can It Save States Money?" which found AOT cut costs in half by reducing the use of more expensive (and liberty infringing) inpatient commitment, hospitalization, and incarceration. See appendix B for other studies.

² Biasotti, Michael C., Management of the severely mentally ill and its effects on homeland security. Naval Postgraduate School, Monterey, CA, September, 2011. Key findings and quotes from officers surveyed attached as appendix. Full report available at <http://mentalillnesspolicy.org/crimjust/homelandsecuritymentalillness.pdf>. (Accessed 3/16/14.)

³ Crime: A 1991 survey of 1,401 members of the National Alliance for the Mentally Ill (NAMI), an advocacy group for families of individuals with serious mental illnesses, reported that 40 percent of the mentally ill family members had been in jail at some point in their lives. Donald M. Steinwachs, Judith D. Kasper, Elizabeth A. Skinner, *Final Report: NAMI Family Survey* (Arlington, Va.: National Alliance for the Mentally Ill, 1992).

⁴ Suicide: There are 38,000 suicides a year. NIMH estimates 90% are mental illness related. We conservatively estimate that half of those are related to untreated serious mental illness (16,000). NIMH says (<http://www.nimh.nih.gov/health/publications/suicide-in-the-us-statistics-and-prevention/index.shtml>) there are 11 attempts for every one suicide. They rely on Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS): www.cdc.gov/ncipc/wisqars

⁵ Victimization: Hiday, Virginia Aldigé, Ph.D.; Swartz, Marvin S., M.D.; Swanson, Jeffrey W., Ph.D.; Borum, Randy, H. Ryan, Psy.D., *Criminal Victimization of Persons With Severe Mental Illness*. Psychiatric Services. American Psychiatric Association. January 1, 1999, Vol 50. Issue 1.

⁶ Homelessness: Estimates of homeless mentally ill vary. In January 2012, the Annual Homeless Assessment Report determined 633,782 people were homeless on a single night in the United States. Sixty-two percent of them (390,155) were sheltered (living in

emergency shelter or transitional housing) and thirty-eight percent (243,627) were unsheltered (living in places not meant for human habitation, such as the streets, abandoned buildings, vehicles, or parks. (Alvaro Cortes, et al. 2012) These estimates do not include homeless “couch-surfers” who camp out on the sofas of friends and families, move every few days and have no permanent address. Estimates of the percentage of homeless who have mental illness range from 25% to 46% (National Alliance to End Homelessness n.d.). Depending on the age group in question, and whether it includes all mental illness or just serious mental illness, the consensus estimate seems to be that at minimum 26% of homeless are seriously mentally ill. (U.S. Department of Housing and Urban Development 2010) Therefore, 164,783 seriously mentally ill are homeless at any given point in time as are 291,539 with any mental illness.

⁷ E. Fuller Torrey, M.D, The Shortage of Public Hospital Beds for Mentally Ill Persons: A Report of the Treatment Advocacy Center. Available at <http://mentalillnesspolicy.org/imd/shortage-hosp-beds.pdf>

⁸ More than 50% of those in jails and prisons have a mental health problem (James and Glaze 2006). However only about 16 or 17% of individuals in federal prisons and 17% of those in jails have serious mental illness. (Osher, et al. 2012) There were 1,504,150 in prisons and 735,601 in jail. (Glaze and Parks 2012) Therefore there were 240,664 seriously mentally ill in prisons and 125,052 seriously mentally ill in jails, or 365,716 adults with serious mental illness in jails and prisons.

⁹ Police were involved in arresting, processing paperwork, investigating and testifying at the trials of the 365,000 seriously mentally ill in jails and prisons, and the 770,000 under probation and parole. There are 4,814,200 individuals under probation or parole. (Glaze and Parks 2012) If the same 16% (Footnote 8) holds true then 770,000 individuals with serious mental illness are under probation and parole.

¹⁰ As NIMH Director Dr. Thomas Insel told the Institute of Medicine earlier this month, “I’d like to say something which I think is unpopular many people in the mental health community. But the data I believe are fairly unambiguous.... An active psychotic illness is associated with irrational behavior--and violence can be part of that.”

- The Epidemiological Catchment Area (ECA) surveys carried out 1980–1983 reported much higher rates of violent behavior among individuals with severe mental illness living in the community compared to other community residents. For example, individuals with schizophrenia were 21 times more likely to have used a weapon in a fight. Swanson JW, Hozer CD, Ganju VK et. al. Violence and psychiatric disorder in the community: evidence from the Epidemiologic Catchment Area surveys. *Hospital and Community Psychiatry* 1990;41:761–770.
- A review of 22 studies published between 1990 and 2004 “concluded that major mental disorders, per se, especially schizophrenia, even without alcohol or drug abuse, are indeed associated with higher risks for interpersonal violence.”

Major mental disorders were said to account for between 5 and 15 percent of community violence. Joyal CC, Dubreucq J-L, Gendron C et al. Major mental disorders and violence: a critical update. *Current Psychiatry Reviews* 2007;3:33–50.

- A study of 331 individuals with severe mental illness in the United States reported that 17.8 percent "had engaged in serious violent acts that involved weapons or caused injury." It also found that "substance abuse problems, medication noncompliance, and low insight into illness operate together to increase violence risk." Swartz MS, Swanson JW, Hiday VA et. al. Violence and severe mental illness: the effects of substance abuse and nonadherence to medication. *American Journal of Psychiatry* 1998;155:226–231.
- In a carefully controlled study comparing individuals with severe mental illness living in the community in New York with other community residents, the former group was found to be three times more likely to commit violent acts such as weapons use or "hurting someone badly." The sicker the individual, the more likely they were to have been violent. Link BG, Andrews H, Cullen FT. The violent and illegal behavior of mental patients reconsidered. *American Sociological Review* 1992;57:275–292.

ATTACHMENT A

**Excerpts from
Management of the Severely Mentally Ill and its Effect on Homeland Security:
A survey of 2400 senior law enforcement officials**

By
Chief Michael Biasotti
Immediate Past President New York State Association of Chiefs of Police
Chief of Police, New Windsor, NY
U.S. Naval Postgraduate School's Center for Homeland Defense and Security
September 2011

Selected Findings

Police and sheriffs are being overwhelmed "dealing with the unintended consequences of a policy change that in effect removed the daily care of our nation's severely mentally ill population from the medical community and placed it with the criminal justice system." "This policy change has caused a spike in the frequency of arrests of severely mentally ill persons, prison and jail population and the homeless population... (and) has become a major consumer of law enforcement resources nationwide."

84.28% (or 1,866) of respondents said there been an increase in the mentally ill population over the length of their career

63.03% (n=1,391) of respondents reported that the time spent on mental illness related calls has increased (during their career). An additional 17.72 percent reported that the time spent had substantially increased, totaling 70.7 percent (n=1,782) of respondents reporting an increase

When asked what the officers' attribute the increase in calls to, 56% said inability to refer mentally ill to treatment and 61% said more persons with mental illness are being released to the community,

The officers claimed that mental illness related calls take significantly longer than larceny, domestic dispute, traffic, and other calls.

When asked, "What obstacles affect the ability of law enforcement to make referrals for persons with mental illness", the inability to refer people unless they are danger to safe or others was cited by 77%; limited availability of services was cited by 57% and procedures required for mandated treatment were cited by 44% (Officers were allowed more than one response).

Selected Quotes from Senior Law Enforcement Officers**Problems Getting Admission to Hospitals**

"The problems are not so much the obstacles but rather when we get them to the hospital we have to sit with them, depending on the incident that occurred, and we have a limited number of officers on duty. And once they are committed, it's only a matter of time before they are released and we end of dealing with them again in another situation."

"No support from the mental health doctors. You take them into the hospital and it takes four to six hours to admit to the ward if you are able to at all."

"In Nevada, the Sheriff is required to transport mentally ill subjects to the State hospitals. These trips can take five to eight hours one way due to the great distances we have to travel."

"The closest state mental health facility is approximately 300 miles from my jurisdiction. The closest private mental health facility is 100 miles. The private facility is quite difficult to work with."

"Our jurisdiction is extremely rural. If a person requires in-patient treatment, then it is a four-hour drive to the hospital, and our ambulance service will not transport. Given that most evaluations take two hours at a minimum that leaves an officer out of service for a minimum of ten hours. Because we have only eight officers including the Chief, it also means calling someone in on their days off to make the transport."

"The whole process is too long. It takes too long to have the patient evaluated. Takes too long to have the committal paper filed with the court. Takes too long to find a facility. Takes too long to have the paper obtained once a judge signs it. Then when the individual makes it to the next facility we get to go through the same thing and length of time on the other end. On average it takes approximately 10 hours. With a small department we have 2 or 3 people working. Basically one of my officers is tied up in this process and I have another officer at time working without backup."

"No mandate for mental health services to accept a person brought in by law enforcement unless they are willing to self-commit. To get a commitment there has to be a plan in place to harm themselves or others and the mental health officer has to work out a hold and make sure there is a bed free. There are far too many people who are off their medication for a number of reasons encounter by law enforcement and in need of assistance getting back on track."

"We refer them to facilities such as Emergency Mental Health (EMH) because they attempt to commit suicide and then for whatever reason are let out six to twelve hours later. I have questioned this as a Police Chief and have been told that it is difficult to predict if a person will actually ever commit suicide. What the hell do we bother bringing them to the hospital for then? I could say the same thing in their living room and save the trip to the hospital."

"After forming the Crisis Intervention Team local facilities found out we knew the regulations related to their responsibilities and they started working with us. There are still some obstacles related to some E.R. doctors, for those we that are not a danger to themselves. For others there are limited beds available and the state continues to cut funding to the support agencies."

Problems getting mental health departments to help the most seriously ill

"In the past, if an officer could articulate to the crisis counselor that a mental subject was a danger to him or others then they would respond and make arrangements for bed space. Now, they rarely come out unless it is an uncontrolled violent person. In some cases, a crisis counselor has asked to speak to the mental subject over the officer's cell phone and 'diagnosed' the mental subject based on that short phone conversation. The problem here is that the officer has made observations and noted the comments made by the mental subject. Most officers would not ever release a dangerous person despite whatever diagnosis is made over the phone. So, the mental subject either gets arrested or goes to a local hospital for evaluation. This wastes resources and takes more of the officer's time—all in the name of protecting one's self from liability."

"Police seem to be the only resource that is mandated to be trained and deal with these individuals in the field, usually because there is a disturbance that prompts the call for these individuals. However, EMS, local hospitals, etc., are not required the same level of participation in the de-escalation of a mental event as the police are."

"(Problem is) Catch and Release attitude of mental health professionals, i.e. anti-suicide contracts, promise not to do it again, etc."

"When subjects suffering from mental illness are confronted by law enforcement in the community if they have been abusing alcohol or illegal drugs most mental health practitioner will not assess these individuals regardless of behavior or symptoms until they are "sober." This requires prolonged periods of police officers and jails having to hold these individuals or protect them in medical facilities until mental health practitioners provide an assessment."

"Our system here requires a medical evaluation before acceptance, consequently its easier to arrest and put into jail since they don't need a medical / physical exam prior to acceptance."

"While no obstacles exist, referring to mental health services does little to protect the public safety. Mental health professional simply coaxed the client into taking their medications while at the facility and then sends them back home. Often times we will just have to deal with them again the next day."

Problems caused by lack of 'need for treatment' standard or "grave disability" standard

"We can get them to the psych unit, but the doctors let them go due to the "dangerous to self or others" criteria."

"The biggest problem does not lie with law enforcement. The problem is found when citizens can't get assistance due to the "danger" requirement. When they have nowhere else to turn they call the police to handle the issue. This takes a large amount of time to then pull strings to try and get help for the citizens."

"Although referrals are easily made, the voluntary involvement of the mental health patient is necessary. If they are not voluntary, and not a danger to themselves there is little that can be done with them."

"We are a small department and often only have one officer on duty at a time. This is VERY dangerous to have only one officer handle a mental health case. When possible, we have more officers' respond."

"We must call a mental health case worker, for OK to commit or county will not pay for it...they will listen to what we have to say...but it's their call if they find a bed for the person."

Attachment B: 10 Independent Kendra's Law (AOT) Studies

(Researched by Mental Illness Policy Org. <http://mentalillnesspolicy.org>)

Independent Study	Findings
May 2011 Arrest Outcomes Associated With Outpatient Commitment in New York State Bruce G. Link, et al. Ph.D. Psychiatric Services	For those who received AOT, the odds of any arrest were 2.66 times greater ($p < .01$) and the odds of arrest for a violent offense 8.61 times greater ($p < .05$) before AOT than they were in the period during and shortly after AOT. The group never receiving AOT had nearly double the odds (1.91, $p < .05$) of arrest compared with the AOT group in the period during and shortly after assignment."
October 2010: Assessing Outcomes for Consumers in New York's Assisted Outpatient Treatment Program Marvin S. Swartz, M.D., Psychiatric Services	Consumers who received court orders for AOT appeared to experience a number of improved outcomes: reduced hospitalization and length of stay, increased receipt of psychotropic medication and intensive case management services, and greater engagement in outpatient services.
February 2010 Columbia University. Phelan, Sinkewicz, Castille and Link. Effectiveness and Outcomes of Assisted Outpatient Treatment in New York State Psychiatric Services, Vol 61. No 2	Kendra's Law has lowered risk of violent behaviors, reduced thoughts about suicide and enhanced capacity to function despite problems with mental illness. <i>Patients given mandatory outpatient treatment - who were more violent to begin with - were nevertheless four times less likely than members of the control group to perpetrate serious violence after undergoing treatment.</i> Patients who underwent mandatory treatment reported higher social functioning and <i>slightly less stigma</i> , rebutting claims that mandatory outpatient care is a threat to self-esteem.
March 2005 N.Y. State Office of Mental Health "Kendra's Law: Final Report on the Status of Assisted Outpatient Treatment."	<p>Danger and Violence Reduced</p> <ul style="list-style-type: none"> * 55% fewer recipients engaged in suicide attempts or physical harm to self * 47% fewer physically harmed others * 46% fewer damaged or destroyed property * 43% fewer threatened physical harm to others. * Overall, the average decrease in harmful behaviors was 44%. <p>Consumer Outcomes Improved</p> <ul style="list-style-type: none"> * 74% fewer participants experienced homelessness * 77% fewer experienced psychiatric hospitalization * 56% reduction in length of hospitalization. * 83% fewer experienced arrest * 87% fewer experienced incarceration. * 49% fewer abused alcohol * 48% fewer abused drugs <p>Consumer participation and medication compliance improved</p> <ul style="list-style-type: none"> * Number of individuals exhibiting good adherence to meds increased 51%. * The number of individuals exhibiting good service engagement increased 103%. <p>Consumer Perceptions Were Positive</p> <ul style="list-style-type: none"> * 75% reported that AOT helped them gain control over their lives * 81% said AOT helped them get and stay well * 90% said AOT made them more likely to keep appointments and take meds. * 87% of participants said they were confident in their case manager's ability. * 88% said they and case manager agreed on what is important to work on. <p>Effect on mental illness system</p> <p>Improved Access to Services. AOT has been instrumental in increasing accountability at all system levels regarding delivery of services to high need individuals. Community awareness of AOT has resulted in increased outreach to individuals who had previously presented engagement challenges to mental health service providers.</p> <p>Improved Treatment Plan Development, Discharge Planning, and Coordination of Service Planning. Processes and structures developed for AOT have resulted in improvements to treatment plans that more appropriately match the needs of individuals who have had difficulties using services in the past.</p> <p>Improved Collaboration between Mental Health and Court Systems. As AOT processes have matured, professionals from the two systems have improved their working relationships, resulting in greater efficiencies, and ultimately, the conservation of judicial, clinical, and administrative resources.</p> <ul style="list-style-type: none"> o There is now an organized process to prioritize and monitor individuals with the greatest need; o AOT ensures greater access to services for individuals whom providers have previously been reluctant to serve; o Increased collaboration between inpatient and community-based providers.

<p>February 2010 Columbia University Phelan, Sinkewicz, Castille and Link. <u>Effectiveness and Outcomes of Assisted Outpatient Treatment in New York State Psychiatric Services, Vol 61, No 2</u></p>	<ul style="list-style-type: none"> * Kendra's Law has lowered risk of violent behaviors, reduced thoughts about suicide and enhanced capacity to function despite problems with mental illness. * Patients given mandatory outpatient treatment - who were more violent to begin with - were nevertheless four times less likely than members of the control group to perpetrate serious violence after undergoing treatment. * Patients who underwent mandatory treatment reported higher social functioning and slightly less stigma, rebutting claims that mandatory outpatient care is a threat to self-esteem.
<p>October 2010: Changes in Guideline-Recommended Medication Possession After Implementing Kendra's Law in New York, Alisa B. Busch, M.D Psychiatric Services</p>	<p>In all three regions, for all three groups, the predicted probability of an M(edication) P(ossession) R(atio) $\geq 80\%$ improved over time (AOT improved by 31–40 percentage points, followed by enhanced services, which improved by 15–22 points, and "neither treatment," improving 8–19 points). Some regional differences in MPR trajectories were observed.</p>
<p>October 2010 Robbing Peter to Pay Paul: Did New York State's Outpatient Commitment Program Crowd Out Voluntary Service Recipients? Jeffrey Swanson, et al. Psychiatric Services</p>	<p>In tandem with New York's AOT program, enhanced services increased among involuntary recipients, whereas no corresponding increase was initially seen for voluntary recipients. In the long run, however, overall service capacity was increased, and the focus on enhanced services for AOT participants appears to have led to greater access to enhanced services for both voluntary and involuntary recipients.</p>
<p>June 2009 D Swartz, MS, Swanson, JW, Steadman, HJ, Robbins, PC and Monahan J. <u>New York State Assisted Outpatient Treatment Program Evaluation. Duke University School of Medicine, Durham, NC, June, 2009</u></p>	<p>We find that New York State's AOT Program improves a range of important outcomes for its recipients, apparently without feared negative consequences to recipients.</p> <ul style="list-style-type: none"> * Racial neutrality: We find no evidence that the AOT Program is disproportionately selecting African Americans for court orders, nor is there evidence of a disproportionate effect on other minority populations. Our interviews with key stakeholders across the state corroborate these findings. Court orders add value: The increased services available under AOT clearly improve recipient outcomes, however, the AOT court order, itself, and its monitoring do appear to offer additional benefits in improving outcomes. * Improves likelihood that providers will serve seriously mentally ill: It is also important to recognize that the AOT order exerts a critical effect on service providers stimulating their efforts to prioritize care for AOT recipients. * Improves service engagement: After 12 months or more on AOT, service engagement increased such that AOT recipients were judged to be more engaged than voluntary patients. This suggests that after 12 months or more, when combined with intensive services, AOT increases service engagement compared to voluntary treatment alone. * Consumers Approve: Despite being under a court order to participate in treatment, current AOT recipients feel neither more positive nor more negative about their treatment experiences than comparable individuals who are not under AOT.
<p>1999 NYC Dept. of Mental Health, Mental Retardation and Alcoholism Services. H. Telson, R. Glickstein, M. Trujillo, Report of the Bellevue Hospital Center Outpatient Commitment Pilot</p>	<ul style="list-style-type: none"> * Outpatient commitment orders often assist patients in complying with outpatient treatment. * Outpatient commitment orders are clinically helpful in addressing a number of manifestations of serious and persistent mental illness. * Approximately 20% of patients do, upon initial screening, express hesitation and opposition regarding the prospect of a court order. After discharge with a court order, the majority of patients express no reservations or complaints about orders. * Providers of both transitional and permanent housing generally report that outpatient commitment help clients abide by the rules of the residence. More importantly, they often indicate that the court order helps clients to take medication and accept psychiatric services. * Housing providers state that they value the leverage provided by the order and the access to the hospital it offers.
<p>1998 Policy Research Associates, Study of the NYC involuntary outpatient commitment pilot program.</p>	<ul style="list-style-type: none"> * Individuals who received court ordered treatment in addition to enhanced community services spent 57 percent less time in psychiatric hospitals.

BY MERSHEL HARDIN

consultant. He was a director of the IACC Civil Liberties Association from 1973 to 1980. He has written and lectured on the importance of liberty and free speech in the lives of all people, especially the mentally ill. One of his children has schizophrenia.

THE PUBLIC is growing increasingly confused by how we treat the mentally ill.

More and more, the mentally ill are showing up in the streets, badly in need of help. Incidents of illness-driven violence are reported regularly — incidents which common sense tells us should be avoided. And this is just the visible tip of the greater tragedy — of many more sufferers deteriorating in the shadows and, often, committing suicide.

People ask in perplexed astonishment: "Why don't we provide help and treatment, when the need is so obvious?" Let every such cry of anguish be met with the cry of indignation that unrequested intervention is an infringement of civil liberties.

This stops everything. Civil liberties, after all, are a fundamental part of our society. The rhetoric and lobbying results in legislative obstacles to timely and adequate treatment, and the psychiatric community is cowed by the threat of litigation if the treatment is not requested.

Here is the Kafkaesque irony: Far from respecting civil liberties, legal obstacles to treatment limit or obstruct them. The best example concerns schizophrenia. The most chronic and disabling of the major mental illnesses, schizophrenia involves a chemical imbalance in the brain, attended in most cases by many attendant symptoms.

Symptoms can include confusion; inability to concentrate, to think abstractly, or to plan; thought disturbances; delusions; hallucinations; and variations such as paranoia. Untreated, the disease is ravaging. Its victims cannot work or care for themselves. They may think they are being persecuted, or they may be cultural characters such as Jesus Christ or John Lennon — or otherwise lose their sense of identity. They find it hard or impossible to live. In the worst cases, they may become hostile and threatening.

Such victims are prisoners of their illness. Their personalities are subsumed by their distorted thoughts. They cannot think or remember their free will. To interfere — with involuntary commitment — is to deny them their civil liberties." As for the tragedy of the victims from this disease, this means that many people who have their illness have little or no insight into their own condition. If you think you are Jesus Christ or an avenging angel, you are not likely to see that you need to go to hospital.

Anti-treatment advocates insist that involuntary commitment should be limited to cases of imminent physical danger. The person in question is going to do serious bodily harm to himself or somebody else. But the establishment of such "dangerousness" usually comes too late. The person has already lost control, leading to violence, happens suddenly. And all the while, the victim suffers the ravages of the illness itself, the degradation of life, the tragic loss of individual potential.

The anti-treatment advocates say:

Uncivil Liberties

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The anti-treatment advocates say:

The opposition to involuntary commitment and treatment betrays a profound misunderstanding of the principles of liberty. The state could not justify this kind of interference with the liberties of anyone who is not a victim of their illness — free them from the Bastille of their psychoses — and restore their dignity, their free will and the meaningful exercise of their liberties. J

ment and civil liberties, as if they were opposites. It is with such a misconception that anti-treatment lobbyists promote legislation loaded with administrative and judicial obstacles to involuntary commitment.

The result, inadvertently for Cull, (as regards guardianship legislation) and the government, will be a situation where the state will be unable to care for its citizens every year, just as surely as if those people were lined up annually in front of a firing squad. Add to that the broader ravages of the illness, and keep in mind the much higher suicide rate for those who also have a high suicide rate.

A doubly ironic downstream effect: the inappropriate use of criminal prosecutions against the mentally ill. The result is that more people are committed to jails and prisons rather than hospitals. B.C. Corrections once estimated that almost one-third of adult offenders and close to one-half of those in the corrections system have a diagnosable mental disorder.

Clinical evidence has now indicated that allowing schizophrenia to go untreated results in a lower rate of recovery, and subsequent psychotic breaks lower that level further — in other words, the cost of withholding treatment is permanent disability.

Meanwhile, bureaucratic roadblocks, such as time-consuming judicial hearings, are passed off under the cloak of "due process" — as if the state were not responsible for the fact that one is being charged and hospitalized for treatment is a punishment. Such cumbersome restraints ignore the existing adequate state-of-the-art procedures for independent assessments and a review panel to check against over-long stays.

How can so much degradation and disability be inflicted in the name of civil liberties? It cannot.

The opposition to involuntary commitment and treatment betrays a profound misunderstanding of the principles of liberty. The state could not justify this kind of interference with the liberties of anyone who is not a victim of their illness — free them from the Bastille of their psychoses — and restore their dignity, their free will and the meaningful exercise of their liberties. J

Mr. MURPHY. Thank you, Chief.
Mr. Dart, you are recognized for 5 minutes.

TESTIMONY OF THOMAS J. DART

Sheriff DART. Thank you, Mr. Chairman and the committee, for having me here today.

I am the Sheriff of Cook County, and as the Sheriff, I run the Cook County Jail, which is the largest single site jail in the country. My office is in the jail. Our average daily population is between 10,000 to 12,000 inmates and it costs about \$143 a day to house someone there.

Since becoming Sheriff in 2006, I have seen an explosion in the percentage of seriously mentally ill individuals housed in the jail. I have seen firsthand the devastating impact cuts to mental health programs and services have had on the mentally ill in Illinois. This is a crisis we must all care about because it affects all of us. I find it ironic that in the 1950s we thought it was inhumane to house people in state hospitals but now in the 21st century we are OK with them being in jails and prisons.

On any given day, an average of 30 to 35 percent of my population suffers from a serious mental illness. The diagnoses fall into two main categories: mood disorders such as major depressive disorder or bipolar disorder, or a psychotic disorder such as schizophrenia. While some mentally ill individuals are charged with violent offenses, the majority are charged with crimes seemingly committed to survive, including retail theft, trespassing, prostitution and drug possession.

A cursory review of our statistics tells the story. Last year in one of my living units, 1,265 men were in that dorm on low-level drug-related offenses. The average length of stay was 87 days. At \$143 a day, it costs over \$12,000 just to house these individuals pretrial because they cannot afford to post a minimal bail or have nowhere to live. Many of these inmates ultimately are sentenced to probation, more often than not, or sentenced to time while they were sitting with me.

The unfortunate and undeniable conclusion is that because of dramatic and sustained cuts in mental health funding, we have criminalized mental illness in this country and county jails and State prison facilities are where the majority of mental health care and treatment is administered.

Three recent case studies illustrate this. J.J. was arrested by the Chicago Police Department last May after a failed attempt to steal sheets or towels from a local Walgreens drug store. When we spoke to him shortly after his arrest, he explained that he took the items off the shelf and as he walked past the cashier and he asked her to charge him. He was arrested and charged with retail theft. The value of the items he stole were \$29.99. He spent 110 days in jail before being sentenced to probation. During his custody, he was stabilized on medication and received drug and mental health treatment. The taxpayers of Cook County spent close to \$16,000 after his failed attempt to steal \$29 worth of sheets.

J.D. suffers from a psychotic disorder and has visions that terrify him. He was arrested in California on a warrant from my county. While in custody in California, he removed one of his eyeballs in

an attempt to stop seeing his visions. He lost sight in that eye. So we were alerted to this issue. He was transferred to our custody 2 weeks ago and recently attempted to remove his other eye. While staff acted quickly, we were able to stop that from occurring. We presently have him where he wears a helmet and face mask and has gloves on his hands.

T.A. was arrested over 100 times. Her most recent arrest came after she attempted to steal \$20 from a person's purse during a church service. She is a chronic self-mutilator. She attacks her arms with her own fingernails or any objects she can find. To keep her safe while in our custody, we make special mittens for her that go up to her armpits. Incredibly, she was sentenced to a prison term and recently was transferred to a state hospital. We are awaiting right now her imminent return to Chicago. She has cost us, the taxpayers, conservatively, over a million dollars for all of her custody.

What we have done in our county now is my staff interviews every detainee before they appear in bond court regarding their mental health history. Those who admit to a history are identified for the public defender's office and then we make efforts to try to appeal to the judges for alternative programs. Unlike State prisoners who have fixed release dates, pretrial detainees may be released at any time, which significantly complicates our ability to provide discharge planning. The inmates are offered written information on available community resources and enrollment in County Care and allowed access to a telephone to contact someone to arrange for transportation home or to identified housing. If the inmate requires discharge to a facility in the next day, we will shelter them overnight before we will try to get them to a hospital. If the inmate requires assistance with transportation to his or her home or a shelter, we will drive them there. If the inmate is stable, coordinated releases are typically initiated by our health care provider and the steps are followed. Additionally, we communicate with the party the inmate is being released to. Once it is confirmed the party is outside the jail, someone from our records unit will go out there to make sure that person is there. The past practice always had been, we released them out to the street where they would wander around aimlessly for hours, if not days.

If the inmate is unstable and in need of psychiatric hospitalization in the community, he or she is petitioned by a licensed mental health professional. A certificate for involuntary hospitalization is completed by psychiatrists and accompanies the individual to the receiving hospital.

Finally, in August, I launched the Mental Health Help Line. It is a 24-hour help line dedicated to assisting former mentally ill detainees or families of mentally ill detainees. The phone line is manned by members of my policy team and supported by our mental health staff. It has been an invaluable resource to the families who communicate with us through this help line. We receive calls on this help line 24 hours a day, 7 days a week.

In conclusion, we are in an unsustainable position. I often refer to the jail as the last car on a long train. Every single day and at every step before a person comes in to the jail, there is discretion: discretion to arrest, to charge and to set bond. But as custodian,

I am obligated to care for those individuals. Every day I am faced with the mental health crisis in this county and in the country. I see the pain of those suffering from mental illness and the pain of their families who have struggled to care for them and provide them with resources. The question that plagues me, that keeps me up at night, is where do we go from here?

As that question is debated, I will continue to do all I can to care for, protect and advocate for increased funding to address mental illness in our country and I will continue to provide the best care I can for the mentally ill. This is truly a crisis that we can no longer ignore.

Thank you.

[The prepared statement of Sheriff Dart follows:]

1. Thomas J. Dart
2. Cook County Sheriff
3. "Where Have All the Patients Gone? Examining the Psychiatric Bed Shortage",
Wednesday, March 26, 2014 10am
4. Subcommittee on Oversight and Investigation

Good morning Chairman and members of this Committee. My name is Thomas J. Dart. I am the Sheriff of Cook County, Illinois and I am honored to be speaking to you this morning about a crisis affecting every state, every community, every prison and every county jail in the nation.

As Sheriff, I run the Cook County Jail, the largest single site jail in the country. Our average daily population is between 10,000-12,000 inmates and it costs \$143 dollars a day to house someone in the jail. Since becoming Sheriff in 2006, I have seen an explosion in the percentage of seriously mentally ill individuals housed in the jail. I have seen first-hand the devastating impact cuts to mental health programs and services has had on the mentally ill in Illinois.

This is a crisis we must all care about – regardless of political affiliation - because it affects us all.

On any given day, an average of 30-35% of the jail's population suffers from a serious mental illness. The diagnoses fall into two main categories – mood disorders such as major depressive disorder or bipolar disorder or a psychotic disorder such as schizophrenia.

While some mentally ill individuals are charged with violent offenses, the majority are charged with crimes seemingly committed to survive, including retail theft, trespassing, prostitution and drug possession.

A cursory review of our statistics tells this story:

Last year 1265 men were in the mental health dorm of the jail on low level drug related offenses. The average length of stay for these inmates was 87 days. At \$143.00 per day, it costs over \$12,000 just to house these individuals *pre-trial* because they cannot afford to post a minimal bail or have nowhere to live.

Many of these inmates ultimately sentenced to probation and far too many times, the case is dropped or the person is sentenced to time considered served and they are released to the community where the vicious and predictable cycle starts over.

The unfortunate and undeniable conclusion is that because of dramatic and sustained cuts in mental health funding, we have criminalized mental illness in this country and county jails and state prison facilities are where the majority of mental health care and treatment is administered.

Three recent case studies illustrate this tragedy:

J.J. was arrested by the Chicago Police Department last May after a failed attempt to steal sheets or towels from a local Walgreens. When we spoke to him shortly after his arrest, he explained that he took the item off the shelf and as walked past the cashier, asked her to “charge these.” He was stopped by the store security guard who called CPD. He was arrested and charged with retail theft. The value of the items he failed to steal was \$29.99. Mr. Jackson spent 110 days in my jail before being sentenced to probation. During his custody, he was stabilized on medication and received drug and mental health treatment. The taxpayers of Cook County spent close to \$16,000 after a failed attempt to steal \$29.99 worth of merchandise from Walgreens.

J.D. suffers from a psychotic disorder and has visions that terrify him. He was arrested in California on a warrant from Cook County. While in custody in California, he removed one of his eyeballs in an attempt to stop seeing the visions. He lost sight in that eye. He was transferred to our custody 2 weeks ago and recently attempted to remove his remaining eye. My staff acted quickly and we are hopeful his sight can be restored. He is under constant and direct supervision.

T.A. has been arrested over 100 times. Her most recent arrest came about after she attempted to steal \$20.00 from a person’s purse during a church service. T.A. is a chronic self-mutilator. She attacks her arms with her own finger nails or any object she can find. To keep her safe while in our custody, we made special mittens that went up to her armpits. Incredibly, she was sentenced to a prison term and recently was transferred to the state department of mental health. All said, the cost to taxpayers for her arrests and incarcerations is, conservatively, over \$1,000,000 and rising.

In light of the challenges we face, we have instituted a number of programs aimed at breaking this cycle.

Bond Court:

My staff interviews every detainee before they appear in bond court regarding their mental health history. Those who admit to a history of mental illness are identified for the public defender's office in the hope that they would be placed in a treatment facility instead of the jail pending trial.

Discharge process:

Unlike state prisoners who have a fixed release date, pre-trial detainees may be released at any time which significantly complicates our ability to provide discharge planning. However we strive to ensure every mentally ill detainee is provided with appropriate medication and resources as they are processed out of our custody.

The inmates are offered written information on available community resources and enrollment in County Care and allowed access to a telephone to contact someone to arrange for transportation home or to identify housing.

If the inmate presents as low functioning or appears to be in need of a mental health assessment to determine his/her ability to navigate the community, the Discharge Lounge officer has him/her escorted to Cermak Urgent Care for an assessment.

If the inmate requires discharge to a facility on the next day, he/she is sheltered on the Cermak acute psychiatric unit.

The inmate is then processed out and given any discharge medication that was turned over to the Discharge unit from Cermak pharmacy as he/she exits.

If the inmate requires assistance with transportation to his/her home, to a shelter or to a therapeutic facility, DOC staff will transport the inmate.

Additional discharge steps are undertaken with low functioning inmates:

If the inmate is stable, coordinated Releases are typically initiated by a Cermak Medical Social Worker for lower functioning mental health and medical inmates. The steps above are followed. Additionally, we communicate with the party the inmate is being released to. Once it has been confirmed that the party is present outside, someone from Records or the Discharge Unit escorts the inmate out to the receiving party.

If the inmate is unstable and in need of psychiatric hospitalization in the community, he/she is petitioned by a licensed mental health professional. A certificate for involuntary hospitalization, completed by a psychiatrist, accompanies the inmate to the receiving hospital. The certifying psychiatrist contacts a local hospital to endorse the inmate's condition to the receiving facility and calls a private ambulance for transport from the Cermak Urgent Care to the facility. If a psychiatrist is not at the facility to complete the certificate, the inmate is sheltered in the Cermak acute psychiatric unit until one is available to complete the discharge process.

Finally, in August, I launched a mental health helpline – a 24 hour phone line dedicated to assisting mentally ill former mentally ill detainees or families of mentally ill individuals in our

custody. This phone line is manned by members of our policy team and supported by our mental health staff. It has been an invaluable resource to us and to the families who communicate with us through this help line.

In conclusion – we are in an unsustainable position. I often refer to the jail as the last car on a long train. Every single day – and at every step before a person comes in to the jail, there is discretion – discretion to arrest, to charge and to set bond. But as custodian, I am obligated to care for those in my custody.

Every single day, I am faced with the mental health crisis in this county. I see the pain of those suffering from mental illness and the pain of their families who have struggled to care for them and provide them with resources. The question that plagues me – that keeps me up at night – is where do we go from here?

As that question is debated, I will continue to do all I can to care for, protect and advocate for increased funding to address mental illness in our country. And I will continue to provide the best care I can for the mentally ill in Cook County..

Thank you for the opportunity to address you this morning.

Mr. MURPHY. Thank you, Sheriff.
I now recognize Judge Leifman for 5 minutes.

TESTIMONY OF STEVE LEIFMAN

Mr. LEIFMAN. Thank you very much, Mr. Chairman, members of the subcommittee. My name is Steve Leifman. I am a Judge for Miami-Dade County and I chair the Florida Supreme Court Task Force on Substance Abuse, Mental Illness and Issues in the Court.

You asked where have the patients gone. Sadly, the answer is jail and prisons, and this is an American travesty. As you already stated, in 1955 there were some 550,000 people in State psychiatric hospitals around this country. If nothing had changed and we use today's population, there would have been about 1.5 million people in State psychiatric hospitals today.

Last year, 1.5 million people with serious mental illnesses were arrested in this country. On any given day in the United States, we have approximately 500,000 people with serious mental illnesses in jails and prisons and another 850,000 in the community on some type of community control or probation. Since 1955, we have closed 90 percent of the hospital beds in this country and we have seen a corresponding increase of 400 percent of the number of people going to jail with mental illnesses, and because jails are not conducive to treatment and courts do not know what to do with this population, people with mental illnesses generally stay four to eight times longer in jail than anyone else with the exact same charge who does not have a mental illness and costs seven times more.

I had no idea that when I become a judge I was actually becoming the gatekeeper to the largest psychiatric facility in the State of Florida, and tragically, that is the Miami-Dade County Jail. I see more people on any given day with mental illness than most psychiatrists see in a month.

People with mental illnesses in this country are three times more likely to be arrested than to be hospitalized, and in my State, it is nine times more likely. The closing of the hospitals is not the only and primary reason all these individuals had ended up in hospitals. It is a combination that created the perfect storm. It includes the IMD exclusion. It includes what Medicaid pays for its services. It includes the war on drugs. It includes the reduction of hospital beds. It includes the antiquated involuntary hospital laws. They have all conspired to create this perfect, perfect storm. And if this wasn't bad enough, just listen to the costs this is having to our communities.

We worked with the Florida Mental Health Institute at the University of South Florida and Tampa. We wanted to know who the highest utilizers of criminal justice and mental health services were in my county so that we could wrap our arms around this population to see if we could get them services so they didn't keep reoffending. I thought I would get a list of thousands of individuals back. They send me a list of 97 people, and I guarantee every one of you have these same 97 in your communities. These 97 individuals, primarily men, primarily diagnosed with schizophrenia, over 5 years were arrested 2,200 times. They spent 27,000 days in the Dade County Jail, 13,000 days at a psychiatric hospital or an emer-

gency room, and cost taxpayers \$13 million, and we got absolutely nothing for it. We would have been better off sending them to Harvard and maybe giving them an opportunity for an education. It is an outrage.

The other part of the problem is that where we spend our money is killing us. In Florida, we spend one-third of all of our adult public mental health dollars—that is almost a quarter of a billion dollars—to try to restore competency for 2,700 people. We have between 170,000 and 180,000 people in any given year in Florida who at the time of their arrest need acute mental health care treatment but we spend a third of our money trying to restore competency so we can try these 2,700 people. Well, 70 percent of these individuals have three things happen to them. Either the charges are dropped because the witnesses disappear, they get credit for time served because they have been in the system so long and they walk out of the front door of the courthouse without any access to treatment, or they get probation and they walk out of the courthouse with any access to treatment and we just spent a quarter of a billion dollars, and that money is coming out of the community mental health system, making it harder for people to get access. It actually meets the definition of insanity. We keep doing the same thing again and again and we expect a different outcome.

It is even worse at the prison level, and on competency restoration, in the United States we are spending almost \$3.5 billion and we are getting very little return for that money.

The fastest growing population in Florida's prisons are people with mental illnesses. While our prison population has begun to stabilize over the last 2 years, the mental health population continues to grow at exceedingly alarming rates. Over the last 15 years, the percentage of people with mental illnesses has grown by 178 percent. We went from about 6,500 people with serious mental illnesses 15 years ago to 18,000 today. It is growing so fast that it is projected to double again in the next 10 years. Florida needs to start building 10 new prisons for the next 10 years just to get to this population. It will cost my State \$3.5 billion to deal with this population if we don't do something soon to correct the problem.

We are looking at a huge cost and we are getting very little for our outcome. We have a three-legged stool that is wobbling and about to break, and there are three parts that I really hope that you are able to address. The first part is how and what we finance through federal Medicaid dollars for mental health services. It doesn't work. The second somebody is no longer a danger to self or others, Medicaid will cut them off and the hospital will discharge them back to the community, often to homelessness, often into the criminal justice system.

The second part that needs to be addressed is the antiquated involuntary hospitalization laws. Most of these laws were written before we had TV, microwave ovens, computers, brain imaging and antipsychotic medication. It is an absurdity. The first laws come from 1788 out of New York. It doesn't work. People cannot get into the system to get treatment, and then when they are ready to be discharged, there is nothing for them.

The third part is that we need to have a coordinated system in the criminal justice system to make sure we can take care of this

population, and let me just make two quick points. We are doing some significant things in Miami-Dade County that are having huge impacts. We have trained over 4,000 police officers in order to identify people with mental illnesses in the community. Last year, the city of Miami and Miami-Dade County did 10,000 mental health calls. These 4,000 officers only made 27 arrests out of these 10,000 calls. Our jail audit plummeted from 7,800 to 5,000, allowing the county to close a jail and saving \$12 million. We also have post-arrest diversion programs where if someone comes in, we get them treated and make sure that they are not just discharged to the community without any assistance.

We are saving lives, we are saving dollars, and we are starting to make the system work, but we need to fix those other three pieces. We also need to begin to use advanced technology, which we are beginning to do. We are part of a unique private and public partnership in Dade County where we are working to see if predictive analytics can actually be used in the behavioral health space so that we can have an unfragmented system of care, more accountability, and make sure that people with mental illnesses are treated fairly and properly.

Thank you very much.

[The prepared statement of Judge Leifman follows:]

STATEMENT OF
JUDGE STEVE LEIFMAN
Chair, Supreme Court of Florida Task Force on
Substance Abuse and Mental Health Issues in the Courts
before the
Subcommittee on Oversight and Investigations
of the Energy and Commerce Committee of the
UNITED STATES HOUSE OF REPRESENTATIVES
concerning
People with Mental Illnesses Involved in the Criminal Justice System

Summary

Nationwide, jails and prisons have become the largest psychiatric facilities in most states. It is estimated that there are nearly 14 times as many people with mental illnesses in jails and prisons in the United States as there are in all state psychiatric hospitals combined.

The initial closing of state hospital beds beginning in the 1950s and 1960s was a response to institutions which had largely become warehouses providing little more than custodial confinement. In 1963, Congress passed the Community Mental Health Centers Act which was intended to create a network of community-based mental health providers that would replace failing and costly state hospitals, and integrate people with mental illnesses back into their home communities with comprehensive treatment and services. Unfortunately, the comprehensive network of community mental health centers and services envisioned never materialized. The community mental health system that did emerge is too often fragmented with poorly integrated services, and enormous gaps in treatment and disparities in access to care.

Today, there are three significant areas of policy and practice contributing to the disproportionate involvement of people with serious mental illnesses in justice system: 1) Limitations on financing of services using federal resources; 2) Reliance on outdated civil commitment laws; and 3) Lack of standardized and systematic coordination of services and resources between the criminal justice system and the community mental health system.

Fortunately, there are promising solutions being developed as the result of problem-solving initiatives at the interface of the criminal justice and mental health arenas. By working collaboratively across systems and disciplines, we now have a greater understanding of the causes and consequences of involvement in the justice system among people with serious mental illnesses.

Introduction

Chairman Murphy, Vice-Chairman Burgess, Ranking Member DeGette, and Members of the Subcommittee:

Thank you for the opportunity to provide testimony today about the critically important issue of people with untreated mental illnesses involved in the criminal justice system. My name is Steve Leifman and since 1995 I have served as a judge in the Eleventh Judicial Circuit in Miami-Dade County, Florida. From 2007 until 2010, I served as Special Advisor on Criminal Justice and Mental Health for the Supreme Court of Florida. Since 2010, I have served as Chair of the Supreme Court of Florida's Task Force on Substance Abuse and Mental Health Issues in the Courts. I also serve as co-chair of the Judges' Leadership Initiative for Criminal Justice and Behavioral Health, an organization established in 2004 consisting of judges from around the country, as well as representatives from the National Center for State Courts, the National Judicial College, Policy Research Associates, and the Council of State Governments Justice Center, working to develop problem-solving approaches to address the disproportionate number of people with serious mental illnesses (e.g., schizophrenia, bipolar disorder, and major depression) involved in the criminal justice system.

When I became a judge nearly two decades ago, I had no idea I would become the gatekeeper to the largest psychiatric facility in the State of Florida. The Miami-Dade County jail contains nearly half as many beds for inmates with mental illnesses as all state civil and forensic mental health hospitals combined. Of the roughly 100,000 bookings into the jail every year, nearly 20,000 involve people with serious mental illnesses requiring intensive psychiatric treatment while incarcerated. On any given day, the jail houses approximately 1,200 individuals receiving psychotherapeutic medications, and costs taxpayers roughly \$65 million annually,

more than \$178,000 per day. Additional costs to the county, the state, and taxpayers result from crime and associated threats to public safety; civil actions brought against the county and state resulting from injuries or deaths involving people with mental illnesses; injuries to law enforcement and correctional officers; ballooning court case loads involving defendants with mental illnesses; and uncompensated emergency room and medical care. In addition to direct fiscal costs to the community, the added stigma of criminal justice system involvement often results in additional hardships and barriers to recovery for consumers of mental health services and their family members in terms of decreased quality of life and difficulty in accessing basic supports such as housing and treatment services.

Several years ago, the Florida Mental Health Institute at the University of South Florida completed an analysis examining arrest, incarceration, acute care, and inpatient service utilization rates among a group of 97 individuals in Miami-Dade County identified to be frequent recidivists to the criminal justice and acute care systems. Nearly every individual was diagnosed with schizophrenia, and the vast majority of individuals were homeless at the time of arrest. Over a five year period, these individuals accounted for nearly 2,200 arrests, 27,000 days in jail, and 13,000 days in crisis units, state hospitals, and emergency rooms. The cost to the community was conservatively estimated at \$13 million with no demonstrable return on investment in terms of reducing recidivism or promoting recovery. Comprising just five percent of all individuals served by problem-solving courts targeting people with mental illnesses, these individuals accounted for nearly one quarter of all referrals and utilized the vast majority of available resources.

As a member of the judiciary, I see first-hand the consequences of untreated mental illnesses both on our citizens and our communities. Former Surgeon General Dr. David Satcher

once called mental illness the silent epidemic of our time. However, for those of us who work in the justice system nothing could be further from the truth. Everyday our courts, correctional facilities, and law enforcement agencies are witness to a parade of misery brought on by untreated mental illnesses.

Part of the reason for this is that, over time and as the result of the unintended consequences of efforts to provide more compassionate alternatives to institutional confinement, public mental health systems across the United States have been funded and organized in such a way as to all but ensure that the most expensive services are provided, in the least effective manner, to the fewest number of individuals; those in acute crisis in inpatient settings.

Because community-based service delivery systems are often fragmented, difficult to navigate, and slow to respond to critical needs, many individuals with the most severe and disabling forms of mental illnesses who are unable to access primary and preventive care in the community eventually fall through the cracks and land in the criminal justice or state hospital systems where service costs are exponentially higher and targeted toward crisis resolution and restoration of competency, as opposed to promoting ongoing stable recovery and community integration. As a result, instead of investing in community-based prevention, treatment, and wellness services, states and communities are increasingly forced to allocate limited mental health funding and resources to costly crises services and inpatient hospital care in both the civil and forensic mental health systems.

Historical Overview

200 years ago, people with severe and disabling mental illnesses were often confined under cruel and inhumane conditions in jails. This was largely due to the fact that no alternative system of competent, community-based mental health care existed. During the 1800's, a

movement known as moral treatment emerged that sought to hospitalize and treat individuals with mental illnesses rather than simply incarcerating them.

The first state psychiatric hospitals were opened in the United States during the late-1700's and early-1800's, and were intended to serve as more appropriate and compassionate alternatives to the neglect and abuse associated with incarceration. Unfortunately, overcrowding at these institutions, inadequate staffing, and lack of effective treatment programs eventually resulted in facilities being able to provide little more than custodial care. Physical and mental abuses became common and the widespread use of restraints such as straight-jackets and chains deprived patients of their most basic dignity and freedom. The asylums intended to be humane refuges for the suffering had instead turned into houses of horrors.

By the mid-1900's, more than a half million people were housed in state psychiatric hospitals across the United States. The system was stretched beyond its limits and states desperately needed some alternative to addressing this costly and ever-expanding crisis. Around this same time, the first effective medications for treating symptoms of psychosis were being developed, lending further support to the emerging belief that people with serious mental illnesses could be treated more effectively and humanely in the community. This period marked the beginning of the community mental health movement.

In 1963, Congress passed the Community Mental Health Centers Act which was intended to create a network of community-based mental health providers that would replace failing and costly state hospitals, and integrate people with mental illnesses back into their home communities with comprehensive treatment and services. In what would be his last public bill signing, President Kennedy signed a \$3 billion authorization to support this movement from institutional to community-based treatment. Tragically, following President Kennedy's

assassination and the escalation of the Vietnam War, not one penny of this authorization was ever appropriated.

As more light was shed on the horrific treatment people received in state psychiatric hospitals, along with the hope offered by the availability of new and effective medications, a flurry of federal lawsuits were filed against states which resulted what became known as the deinstitutionalization of public mental health care. Unfortunately, there was no organized or adequate network of community mental health centers to receive and absorb these newly displaced individuals.

The fact that a comprehensive network of community mental health centers and services were never established has resulted in a fragmented continuum of care that has failed to adequately integrate services, providers, or systems; leaving enormous gaps in treatment and disparities in access to care. Furthermore, the community mental health system that was developed was not designed to serve the needs of individuals who experience the most chronic and severe manifestations of mental illnesses.

In two centuries, we have come full circle, and today our jails are once again psychiatric warehouses. There are two ironies in this chronology that have resulted in the fundamental failure to achieve the goals of the community mental health movement and allowed history to repeat itself in costly and unnecessary ways:

- First, despite enormous scientific advances, treatment for severe and persistent mental illnesses was never deinstitutionalized, but rather was transinstitutionalized from state psychiatric hospitals to jails and prisons.

- Second, because no comprehensive and competent community mental health treatment system was ever developed, jails and prisons once again function as de facto mental health institutions for people with severe and disabling mental illnesses.

Current Crisis

The problems currently facing our communities and criminal justice systems relate to the fact that the community mental health infrastructure was developed at a time when most people with severe and disabling forms of mental illnesses resided in state hospitals. As such, the community mental health system was designed around individuals with more moderate treatment needs, and not around the needs of individuals who experience highly acute and chronic mental illnesses. People who would have been hospitalized 40 years ago because of the degree to which mental illness has impaired their ability to function are now forced to seek services from an inappropriate, fragmented, and unwelcoming system of community-based care. Oftentimes when these individuals are unable access to services through traditional sources, their only options to receive treatment is by accessing care through the some of the most costly and inefficient points of entry into the healthcare delivery system including emergency rooms, acute crisis services, and ultimately the juvenile and criminal justice systems.

According to the National Alliance on Mental Illness, 40 percent of adults who experience serious mental illnesses will come into contact with the criminal justice system at some point in their lives. The vast majority of these individuals are charged with minor misdemeanor and low level felony offenses that are a direct result of their psychiatric illnesses. Roughly three-quarters of this population also meets criteria for a co-occurring substance use disorder, which complicates treatment needs.

Over the past 50 years, the number of psychiatric hospital beds nationwide has decreased by more than 90 percent, while the number of people with mental illnesses incarcerated in jails and prisons has grown by 400 percent. Today, it is estimated that there are nearly 14 times as many people with mental illnesses in jails and prisons in the United States as there are in all state psychiatric hospitals combined.

According to the most recent prevalence estimates, 16.9 percent of all jail detainees (14.5 percent of men and 31.0 percent of women) experience serious mental illnesses. Each year, roughly 2.2 million people experiencing serious mental illnesses requiring immediate treatment are arrested and booked into jails nationwide. On any given day, 500,000 people with mental illnesses are incarcerated in jails and prisons across the United States, and 850,000 people with mental illnesses are on probation or parole in the community. People with mental illnesses remain incarcerated 4-8 times longer than people without mental illnesses for the exact same charge, and at a cost 7 times higher.

Forensic Commitment

Individuals ordered into forensic commitment have historically been one of the fastest growing segments of the publicly funded mental health marketplace in Florida. Between 1999 and 2007, forensic commitments increased by 72 percent, including an unprecedented 16 percent increase between 2005 and 2006. In 2006, Florida experienced a constitutional crisis when demand for state hospital beds among people with mental illnesses involved in the justice system outpaced the number of beds in state treatment facilities. With an average waiting time for admission of three months, the Secretary of the Department of Children and Family Services (DCF) was found in contempt of court. The state was forced to allocate \$16 million in emergency funding and \$48 million in recurring annual funding to create 300 additional forensic

treatment beds. Florida currently spends more than \$210 million annually – one third of all adult mental health dollars and two thirds of all state mental health hospital dollars – on 1,700 beds serving roughly 3,000 individuals under forensic commitment.

Nationally, it is estimated that \$3.2 billion is spent annually for forensic competency restoration services. This figure, which is steadily growing, represents nearly one-third of all state hospital spending on what amounts to just a small fraction of individuals deemed to lack the capacity to participate in legal proceedings. Furthermore, because competency restoration has constitutional implications, it has become an entitlement program. As the number of people entering the justice system has exploded, the number of people entering the forensic treatment system has experienced similar growth. Rather than appropriating additional funding to keep up with this growth in demand, most states have simply shifted resources from the civil system to pay for the forensic system. The result has been fewer services available to those outside of the criminal justice system, which has consequently led to more justice system involvement.

State Prison Populations

People with mental illnesses also represent the fastest growing sub-population within Florida's prison system. Between 1996 and 2012, the overall inmate population in Florida prisons increased by 56 percent. By contrast, the number of inmates receiving ongoing mental health treatment in state prisons increased by 160 percent. Inmates experiencing moderate to severe mental illnesses increased by 178 percent. Based on historic growth rates, the number of beds serving inmates with mental illnesses is projected to nearly double in the next decade from nearly 18,000 to more than 32,000 beds. This represents an increase of 1,500 beds – enough to fill at least one prison – per year. Capital and operating costs for new mental health beds alone is

projected to reach nearly \$2.5 billion in the next decade, with annual operating expenditures for mental health beds of nearly \$750 million.

The total cost to house people with mental illnesses in Florida's prisons and forensic treatment facilities is approximately \$625 million dollars annually, or \$1.7 million per day. Another \$400 million dollars annually, \$1.1 million per day, is spent housing people with mental illnesses in local jails. Based on recent growth rates, if nothing changes state expenditures will increase by as much as a billion dollars annually over the next decade.

Impact of Failed Policy and Practice

There are three significant areas of policy and practice contributing to the disproportionate involvement of people with serious mental illnesses in justice system:

1) Limitations on financing of services using federal resources: Rules and regulations regarding federal financing and reimbursement for services provided to people with serious mental illnesses present challenges to designing effective and flexible service delivery. The Substance Abuse and Mental Health Services Administration (SAMHSA) and the Centers for Medicare and Medicaid Services (CMS) are two agencies housed within the United States Department of Health and Human Services (DHHS). SAMHSA has identified numerous treatment modalities, such as intensive case management, psychosocial rehabilitation, supported employment, and supported housing, which consistently yield positive outcomes for people with serious mental illnesses. However, because they do not meet the CMS criteria for "medical necessity," entitlement programs such as Medicaid cannot be used to pay for such services. Similarly, restrictions on federal financial participation for services provided in "institutions for mental disease" mean that, in many instances, inpatient services are simply not covered regardless of established medical necessity.

2) Reliance on outdated civil commitment laws: Prior to the development of effective treatments for serious mental illnesses, there was general consensus that custodial confinement was the lesser of evils for people deemed to be in acute psychiatric distress. While the public had been aware of abuses and neglect that occurred in such facilities since the 1800s, the fact that there were no effective medications and few options for therapeutic intervention meant that there were often no viable alternatives for placement. As such, early approaches to civil commitment were based almost exclusively on the belief that it was the responsibility of the government to protect the broader community from people with mental illnesses who may be dangerous. In fact, the very first civil commitment law to be enacted in New York State in 1788 allowed for, "...any two or more justices of the peace to cause [a person with mental illness] to be apprehended and kept safely locked up in some secure place, and, if such justices shall find it necessary, to be there chained..."

Mental health laws predicated chiefly on dangerousness criteria to the relative neglect of need for treatment, mean that systems often have no choice but to release individuals known to be in acute distress back to the streets, often with no treatment at all. The irony is that if a hospital or healthcare professional were to discharge a person with an acute, non-psychiatric medical crisis, they could be accused of malpractice. However, when psychiatric treatment facilities engage in this behavior, most often because the imminent risk of harm has passed for the moment and/or insurance benefits will no longer pay for continued inpatient admission, they are simply following the law. This is a dangerous precedent and one which has resulted in unnecessary and harmful consequences.

3) Lack of standardized and systematic coordination of services and resources between the criminal justice system and the community mental health system: The justice system was

never intended to serve as the safety net for the public mental health system and is ill-equipped to do so. Jails and prisons across the United States have been forced to house an increasing number of individuals who are unable to access critically needed care in the community. In many cases, necessary linkages between the justice system and the community for individuals coming out of jails and prisons simply don't exist. As a result, individuals who may have been identified and received care while incarcerated are routinely released to the community with no reasonable plan or practical means for accessing follow-up services.

The failure to design and implement an appropriate and comprehensive continuum of community-based care for people who experience the most severe forms of mental illnesses have resulted in:

- Substantial and disproportionate cost shifts from considerably less expensive, front end services in the public mental health system to much more expensive, back-end services in the juvenile justice, criminal justice, and forensic mental health systems
- Compromised public safety
- Increased arrest, incarceration, and criminalization of people with mental illnesses
- Increased police shootings of people with mental illnesses
- Increased police injuries
- Increased rates of chronic homelessness

Promising Solutions

To effectively and efficiently address the most pressing needs currently facing the community mental health and criminal justice systems, it is essential that states and communities be given the resources and flexibility to invest in redesigned and transformed systems of care oriented around ensuring adequate access to appropriate prevention and treatment services in the

community, minimizing unnecessary involvement of people with mental illnesses in the criminal justice system, and developing collaborative cross-systems relationships that will facilitate continuous, integrated service delivery across all levels of care and treatment settings.

Policies and services must be adopted which prevent individuals from unnecessarily entering the justice system to begin with, and which respond to individuals who do become involved in the justice system quickly and effectively to link them to appropriate community-based services that will foster adaptive community living and decrease the likelihood of recidivism to the justice system. Fortunately, numerous programs have been developed that seek to establish collaborative relationships among stakeholders in the criminal justice and community mental health treatment systems, with the goal of facilitating enhanced linkages to community-based mental health and substance abuse treatment. Examples include crisis intervention teams, post-booking jail diversion programs and mental health courts, reentry programs that assist with linkages to treatment and support services, and community corrections programs that employ specially trained officers who apply problem-solving strategies to enhance compliance with terms of probation or parole (for an online database of collaborative criminal justice/mental health programs from across the United States, visit

<http://csgjusticecenter.org/reentry/local-programs-database/>).

11th Judicial Circuit Criminal Mental Health Project

The Eleventh Judicial Circuit Criminal Mental Health Project (CMHP) was established in 2000 to divert individuals with serious mental illnesses or co-occurring SMI and substance use disorders, who do not pose significant public safety risks, away from the criminal justice system into community-based treatment and support services. The project operates two primary components: 1) pre-booking diversion consisting of Crisis Intervention Team (CIT) training

provided at no cost to all law enforcement agencies in the county and 2) post-booking diversion serving individuals arrested and charged with misdemeanor and less serious felonies. To date, the CMHP has provided CIT training to approximately 4,000 law enforcement officers from all 36 municipalities in Miami-Dade County, as well as Miami-Dade Public Schools and the Department of Corrections and Rehabilitation. Countywide, CIT officers respond to roughly 16,000 mental health crisis calls per year. In 2012, CIT officers from the Miami-Dade Police Department and City of Miami Police Department responded to nearly 10,000 mental health related calls, resulting in over 2,100 diversions to crisis units and just 27 arrests. As a result, the average daily census in the jail dropped from 7,800 to 5,000 inmates. The county was able to close one entire jail at a cost-savings to taxpayers of \$12 million per year.

Post-booking jail diversion programs operated by the CMHP serve approximately 500 individuals with serious mental illnesses annually. Over the past decade, these programs have facilitated roughly 4,000 diversions of defendants with mental illnesses from the county jail into community-based treatment and support services. Recidivism rates among program participants charged with misdemeanors decreased from roughly 75 percent to 20 percent annually. Individuals charged with felony offenses have demonstrated reductions in jail bookings and jail days of more than 75 percent, with those who successfully complete the program having a recidivism rate of just 6 percent.

Judges Leadership Initiative

In 2004, the Judges' Leadership Initiative for Criminal Justice and Behavioral Health (JLI) was created. Led by an advisory board comprising judges from around the country, the organization includes representatives from the National Center for State Courts, the National Judicial College, Policy Research Associates, and the Council of State Governments Justice

Center. The organization brings judges from all levels of state judiciaries together to improve judicial understanding of, and responses to, individuals with mental illnesses in our nation's courts. The JLI's mission is to stimulate, support, and enhance efforts by judges to take leadership roles on criminal justice and behavioral health issues to improve judicial, community, and systemic responses to justice-involved people with behavioral health issues.

Since its establishment, the JLI has promoted improved understanding of the effective responses to defendants with mental illnesses through three benchbooks titled, the *Judges' Guide to Mental Health Jargon*, the *Judges' Guide to Mental Health Diversion Programs*, and the *Judges' Guide to Juvenile Mental Health Jargon*. It has also developed a benchcard, *Judges' Guide to Mental Illnesses in the Courtroom*, provided technical assistance to state supreme court chief justice-led planning efforts in 11 states, and embarked on a collaborative outreach effort with the Department of Veterans Affairs to address the mental health needs of criminal-justice involved individuals who have served in the military.

From 2010 to the present, the JLI has partnered with the American Psychiatric Foundation and a newly convened *Psychiatric Leadership Group for Criminal Justice* to develop a training program for judges on mental illnesses in the courtroom and a bench card listing observations and recommended responses for judges who believe mental illness may be affecting a defendant appearing in court. The module has been presented to enthusiastic judicial audiences in Illinois, Wisconsin, Oregon, and Utah, with 2014 trainings planned for Missouri and Texas. Pairs of judges and psychiatrists from around the country have been prepared to present the module.

Typical or Troubled?™ Program

Recently, the CMHP partnered with the American Psychiatric Foundation and Miami-Dade County Public Schools to implement the *Typical or Troubled?™* School Mental Health Education Program for all public junior high and high schools in the Miami-Dade system. The program will train over 500 teachers, school psychologists, social workers and guidance counselors on early identification of potential mental health problems, will educate and engage parents and will ultimately link students with mental health services when needed.

Typical or Troubled?™ is an educational program that helps school personnel distinguish between typical teenage behavior and evidence of mental health warning signs that would warrant intervention. The program includes culturally sensitive technical assistance for school personnel on best practices and educational materials in English, Spanish and forthcoming in Haitian Creole. To date, the program has been used in over 500 schools and school districts, in urban, suburban and rural areas, and educated more than 40,000 teachers, coaches, administrators, and other school personnel across the country.

Leveraging Information Technology

People with serious and persistent mental illnesses who become involved in the criminal justice system demonstrate substantial disparities in rates of access to community-based mental health and primary care services. Patterns of service utilization tend to reveal disproportionate use of costly crisis and acute care services, with limited and inconsistent access to prevention and routine care. Traditionally, criminal justice/mental health responses targeting these individuals have been oriented around interventions that are provided only after an individual becomes involved in the justice system.

Recent developments in information technology have begun to explore whether advanced data analysis tools, such as predictive analytics, may be used to identify patterns of behavior and service utilization which precede crisis episodes. Doing so would represent substantial progress in the ability to administer services and supports proactively, and to developing more effective and targeted treatment protocols. Since 2012, Otsuka Pharmaceuticals, IBM, and the South Florida Behavioral Health Network have been working to develop such a system to enhance care coordination, reduce fragmentation in the system of care, ensure greater accountability, and identify warning signs of potential crises before they occur so that less costly prevention services can be administered. The system is designed to connect providers of mental health services including system leaders, payers, community mental health centers, hospitals, criminal justice systems, and social program organizations. It is expected to help create more comprehensive patient health records. Customized to meet the unique needs of each community that uses it, the focus across users will remain on improving the quality and efficiency of patient care.

The technology platform combines IBM software to coordinate care, and various data management tools with Otsuka's deep disease-specific subject matter expertise in mental health to improve the following:

- Utilization management, including eligibility, enrollment and consent
- Care coordination across clinical and social programs settings
- Insights into patient risk factors, crisis onset, crisis patterns, and costs
- Patient engagement in care management plan
- Organizational change management support

Conclusion

Research and practice have generated many creative and inspired problem-solving initiatives at the interface of the criminal justice and mental health arenas. By working collaboratively across systems and disciplines, a greater understanding of the causes and consequences of involvement in the justice system among people with serious mental illnesses has blossomed. We now know much more about what works and what does not work in the effort to address the problems associated with untreated mental illnesses and criminal justice system involvement.

Going forward, the ability to effectively design, implement, and fund high quality services targeting specialized treatment needs of people with mental illnesses involved in or at risk of becoming involved in the criminal justice system will require a collective commitment to re-evaluating some basic assumptions about the problems we are trying to solve. The current state of affairs in mental health policy and practice has led to a “perfect storm” of sorts. The gap between research and practice is substantial. There are many examples of high quality programs demonstrating “what works” in different communities and at different points in the criminal justice system. Yet one look at “treatment as usual” in many communities would suggest that our typical practice of mental health interventions in criminal justice settings has remained stagnant for decades.

As states and communities struggle with economic hardships, maintaining funding for existing services (let alone securing additional resources) is challenging. One reason for this is that many jurisdictions have become acquiescent to systems of care driven by disproportionate investment in costly, deep-end crisis service at the expense of more effective and sustainable prevention and community treatment. We need to reexamine the ways in which existing

resources are allocated to ensure that states and communities consistently purchase appropriate services that are likely to produce a favorable return on investment.

Technology permits the sharing of information around the world, yet organizations within local communities remain siloed. We need to implement information technology solutions that facilitate more efficient information sharing, and analyses that facilitate better community coordination and organization of the systems of care. We also need to reevaluate policies and laws surrounding mental health and provision of involuntary treatment services, particularly during times of crisis and early episodes of onset of illness. Responding more effectively and strategically in these situations is critical if we are to prevent chronic impairment, reduce demand for services in acute care and institutional settings, and promote recovery in the community.

The policies and laws that guide much of what we do today were an effort to correct the consequences of an abusive and coercive system of care. There is no argument that bad treatment, in bad hospitals, driven by bad policies, was bad for people, but the circumstances that exist today are much different, and our policies and laws should reflect the contemporary landscape of science and the community.

Mr. MURPHY. Thank you, Judge. I was afraid to gavel a judge.
 Judge LEIFMAN. And I appreciate that, and I won't hold anyone
 in contempt today, so appreciate the reciprocation.

Mr. MURPHY. I don't think this is your jurisdiction, so we are
 good.

Judge LEIFMAN. Thank you.

Mr. MURPHY. But thank you for your testimony.

Mr. Stern, you are recognized for 5 minutes.

TESTIMONY OF GUNTHER STERN

Mr. STERN. Thank you for hearing me today. I am here to talk
 about people who are homeless with severe, untreated mental ill-
 ness. I have been working with homeless people for nearly 30
 years, for the last 24 at Georgetown Ministry Center. Our goal
 back in 1990 was to put ourselves out of business by ending home-
 lessness. Instead, homelessness has become a career for me and so
 many others. It has now been 10 years since cities around the
 country including Washington, D.C., issued their 10-year-plan to
 end homelessness. Not much has changed.

Why is homelessness so hard to solve? From my perspective, it
 is because we lack the tools to intervene when a person's life has
 devolved to the point where he or she has moved out onto the
 street because of an untreated mental illness. When I began to
 work with the homeless population nearly 30 years ago, deinstitu-
 tionalization was in full swing. At the time many people I was
 working with were cycling in and out of hospitals. The community
 mental health centers were trying to figure out what their role
 was.

As deinstitutionalization has continued, I have noticed that it is
 increasingly harder to access beds for people in acute psychiatric
 crisis. In the past 2 years, I have only seen two people admitted
 to the hospital. More typically now, people referred for psychiatric
 crisis get poor or no intervention and are returned to the street, al-
 most always because they refuse treatment.

Georgetown Ministry Center brings free psychiatric and medical
 care to the streets but very few people with untreated mental ill-
 ness are willing to engage in conversations with our psychiatrists
 about their mental health. It is the nature of the illness.

However, when we talk about a shortage of beds for treatment,
 we are not talking about the people I work with because these peo-
 ple with limited or no insight into their illness don't think they
 need treatment and vehemently refuse treatment when it is of-
 fered.

Homeless people are real people with families like yours and
 mine, families that care. Greg is someone I met sitting on a park
 bench near our center. He was shabbily dressed and smelled bad.
 He would drink, I assume to tame the voices that I knew he heard
 because of the frequent spontaneous smiles and grimaces. All this
 belied the fact that Greg was once a gifted constitutional lawyer
 who delighted his children with his dry wit. They were in their late
 teens when he began to show the signs of what would become a
 profoundly disabling bipolar disorder. Not long after, he dis-
 appeared. He would call occasionally on birthdays or out of the blue
 for no reason. The kids tried so hard to keep up with him. They

wanted desperately to make him whole again but it was futile. Greg drifted from city to city around the country, ending up in our center, ultimately in our small shelter one winter 8 years ago. Greg was a delight some of the time. His thick southern drawl and witty conversation would enchant volunteers, but other times he was withdrawn and surly. In January of 2006, Greg became sick. We encouraged him to go to the hospital and he said that he would. Instead, he disappeared. A week later I received a call from the medical examiner's office. They needed a body identified. It was Greg. The bodies never look the way you remember a person. Only Greg's face and hair showed from the white shroud covering his body. It took a few moments to work out that these were the features of the person that I once knew.

A few years later, I met Greg's two adult children. They had learned he had died in Washington 3 years after the fact. Each of them traveled, one from New York, the other from Phoenix, to meet here and see the place where their dad spent his final days. They needed to know what his last days were like. I shared coffee with them, and they told stories about him and they asked questions about his final days. They laughed and they cried. You could tell that they loved and missed their father.

There are so many stories I could tell if I had time about mothers, brothers, sons, daughters who have wept for their relatives lost to mental illness. If the families had the tools to intervene, they would intervene.

Most of all, what I want to impart here is that people who live on the street are real people with families and hopes and dreams abandoned because of an illness that has robbed them of their competency. The other important takeaway is that almost all the people I see on the street are there because they have refused treatment, not for rational reasons but because illness has insidiously robbed them of their insight to understand that they have an illness and that treatment can help them.

So finally, what I have concluded after nearly 30 years of working with people who are homeless is that all I can do is provide some comfort and harm reduction. Until we are given tools for more assertive interventions, we will not resolve homelessness.

Thank you.

[The prepared statement of Mr. Stern follows:]

Georgetown Ministry Center
1041 Wisconsin Avenue, NW
Washington, DC 20007 (202) 338-8301
Testimony of Gunther Stern, Executive Director
Wednesday, March 26, 2014,
Subcommittee on Oversight and Investigations hearing entitled:
“Where Have All the Patients Gone? Examining the Psychiatric Bed Shortage.”
March 26, 2014

It is impossible to talk about people with severe, untreated, mental illness without talking about homelessness. Homelessness and mental illness are inextricably intertwined. It is true that the people who are experiencing both severe mental illness and homelessness are a small part of the total population of people with mental illness, but this is the entirety of the face of homelessness that most see on the street pushing carts and sleeping in cardboard boxes.

I started working with homeless people in 1986 at a soup kitchen in Silver Spring, Maryland. I had just finished graduate school and this was going to be a temporary position. That was 28 years ago. I have been working at the Georgetown Ministry Center in Washington, DC for the past 24 years. Our goal back in 1990 was to put ourselves out of business by ending homelessness. Instead homelessness has become a career for me and so many others. It has now been ten years since cities around the country, including Washington, DC issued their *Ten Year Plan to End Homelessness*. We have just as many people on the street with severe mental illness. Why is homelessness so hard to solve.

From my perspective it is because we lack the tools to intervene when a person's life has devolved to the point that he or she has have moved out onto the street because of an untreated mental illness.

When I began to work with the homeless population nearly 30 years ago deinstitutionalization was in full swing. At the time many of the people I was working with were cycling in and out of hospitals. The Community Mental Health Centers were trying to figure out their role. As deinstitutionalization has continued I have noticed that it is increasingly harder to access beds for people in acute psychiatric crises. In the past two years I have only seen two people admitted to the hospital. More typically now, people we refer for psychiatric crisis care get poor or no intervention and are returned to the street. Almost always because they refuse treatment.

Georgetown Ministry Center brings free psychiatric and medical care to the streets but very few people with untreated mental illness are willing to engage in a conversation with the psychiatrists about their mental health. It is the nature of the illness. Treatments have gotten so much better over the last thirty years. We really can treat these illnesses. However, when we talk about a shortage of beds for treatment we are not talking about the people I work with because these people, with limited or no insight into their illness, don't think they need treatment and vehemently refuse treatment when it is offered.

Homeless people are real people with families like yours or mine. Families that care. Greg is someone I first met sitting on a bench in a nearby park. He was shabbily dressed and smelled bad. He would drink, I assume, to tame the voices I knew he heard because of the frequent spontaneous smiles and grimaces. All this belied the fact that Greg was once a gifted constitutional lawyer who delighted his children with his dry wit. They were in their late teens when he began to show the signs of what would become a profoundly disabling bipolar disorder. Not long after, he disappeared. He would call occasionally on a birthday or out of the blue for

no reason. His kids tried so hard to keep up with him. They wanted desperately to make him whole again but it was futile. Greg drifted from city to city around the country, ending up in our center and ultimately in our small shelter one winter eight years ago. Greg was a delight some of the time. His thick southern drawl and witty conversation would enchant volunteers, but other times he was withdrawn and surly.

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So finally, what I have concluded after 30 years of working with people who are homeless is that all I can do is provide some comfort and harm reduction. Until we are given tools for more assertive interventions, we will not resolve homelessness.

Mr. MURPHY. Thank you, Mr. Stern.
Mr. Rahim, you are recognized for 5 minutes.

TESTIMONY OF HAKEEM RAHIM

Mr. RAHIM. Chairman Murphy, Ranking Member DeGette and members of the subcommittee, my journey with mental illness began in 1998 during my freshman year at Harvard University. That fall I experienced a terrifying panic attack. In that episode I had heart palpitations, sweaty palms and dizziness yet I did not know it was an anxiety-induced state. What I did know, however, was the deep terror I felt.

My journey continued when I had my first manic episode. During the spring of 1999, I roamed the streets of Hempstead, New York, possessed with a prophetic delusion that I had to share with any and every one I met. Concerned, my parents sent me to my father's homeland of Grenada to relax and be with family. However, while there, I plunged into a deep depression. I returned to Harvard that fall and struggled through the year battling anxiety and depression.

In the spring of 2000, I was consumed by my second manic episode. My next 2 weeks were filled with sleepless nights and endless writing sessions. I showered less frequently and ate sporadically. During this manic episode, I experienced psychosis. I had visions of Jesus, heard cars talking and spoke foreign languages. Upon hearing my condition, my parents rushed to pick me up from Harvard's campus. That same evening, my parents decided to take me to a psychiatric hospital in Queens. When we arrived at the emergency room, I was taken to the triage area. Over the next few hours, I was held in a curtained room in the ER. I tossed and turned and remained restless, as now I had not slept in 24 hours. My parents sat in the curtained room with me until I was admitted to the hospital later that night.

Accompanied by two hospital aides, I was transported to the psychiatric ward in a hospital van. I walked through the dimly lit ward door and was met by approximately six staff members. They gave me a hospital gown, requested I change into it, and encouraged me to relax when they noted my agitated state. When I continued to toss, the staff stated they were going to put straps around my arms and legs. After placing the straps, they then said they were going to give me a sedative to help me sleep. I felt a prick on my upper arm.

The next morning I awoke, drowsy and unable to speak. I walked to the common room on the ward, sat down and began to hold my breath. I received another sedative. I was hospitalized for 2 weeks. The first week is a blur due to my mental confusion and the psychiatric medication administered to me.

However, I do remember some of my experiences. I interacted frequently with staff and the other patients. One staff member I felt an affinity toward and spoke with him frequently. He advised me to focus on getting better and to not come back to the hospital as so many other patients had. My psychiatrist on the ward diagnosed me with bipolar disorder and briefly explained that I would be on several medications. Upon my release from the hospital I found and met with a psychiatrist in Brooklyn.

During my hospitalization, I accepted my illness and began my arduous road to recovery. I cannot pinpoint what triggered my immediate acceptance, but I am grateful it did not take years for me to obtain insight. Over the course of my 16-year journey with mental illness, I have simultaneously embraced my diagnosis and realized that I am more than a label. I have embraced that I am more than medication, therapist appointments and support groups. I have learned that I am not bipolar, I am Hakeem Rahim, and not just any one piece of my treatment regimen.

At the same time, I have learned that a good treatment regimen has to be accompanied by positive coping skills, diet, exercise for brain health, along with spirituality and spiritual perspective.

The biggest challenge I faced getting to where I am now was openly acknowledging my mental illness. For so long, I felt a deep and personal shame for having bipolar disorder. This shame was so entrenched that I even felt uncomfortable sharing my diagnosis with close friends and even family members.

In 2012, I decided to speak openly and joined NAMI's In Our Own Voice program. Through the In Our Own Voice program, I have shared my story with over 600 people including individuals living with mental illness and their family members. Currently, I am the NAMI Queens/Nassau's Let's Talk Mental Illness presenter. Through the Let's Talk Mental Illness program, I have shared my story and provided much needed awareness to over 5,000 high school students and middle school students at 37 schools. I see the importance in and will continue to speak up for mental health and mental illness education in schools and beyond.

Millions of people in America desire to give voice to their struggles, but cannot because of stigma. I am fueled by the desire to break the silence. I am inspired by students who want to learn about mental illness to help a friend or a struggling parent who is hurting. I am strengthened by people who have decided to out themselves in an effort to normalize mental illness. Mental illness education and awareness is essential to combat stigma, end suffering and to normalize seeking help.

I am grateful to my parents, family and loved ones who have supported me. I am also grateful for this committee for picking up this topic as well as this panel because it is my hope that the ideas put forth today will transform the already shifting conversation around mental illness, and I thank you very much.

[The prepared statement of Mr. Rahim follows:]

Chairman Murphy, Ranking Member DeGette, and Members of the Subcommittee:

My journey with mental illness began in 1998 during my freshman year at Harvard University. That fall I experienced my first terrifying panic attack. In that episode, I experienced heart palpitations, sweaty palms and dizziness, yet I did not know that it was an anxiety-induced state. What I did know however, was the deep terror I felt.

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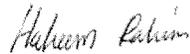
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treatment regimen has to be accompanied by positive coping skills – diet, exercise for brain health, along with spirituality for spiritual perspective.

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Millions of people in America desire to give voice to their struggles, but cannot because of the stigma. I am fueled by the desire to break the silence. I am inspired by students who want to learn about mental illness to help a friend or a struggling parent who is hurting. I am strengthened by people who have decided to "out" themselves in an effort to normalize having a mental illness. Mental illness education and awareness is essential to combat stigma, end suffering and to normalize seeking help. It is my hope that the ideas put forward today transform the already shifting conversation around mental illness.

Sincerely,

A handwritten signature in cursive script that reads "Hakeem Rahim".

Hakeem Rahim
Mental Health Educator, Speaker and Advocate

Mr. MURPHY. Thank you, Mr. Rahim. We appreciate that.
Dr. Edgerson.

TESTIMONY OF LAMARR D. EDGERSON

Mr. EDGERSON. My name is Dr. LaMarr Demetri Edgerson, and I wish to thank the chairman and ranking member for the opportunity to testify today at this very important hearing on the psychiatric bed shortage. My doctorate is in psychology. I am a clinical mental health counselor and licensed marriage and family therapist.

The population we are focusing on today is the population that I primarily serve in my private practice. Over the past year, I have served as the Director at Large for the American Mental Health Counselors Association, also known as AMHCA. I am here representing AMHCA's 7,100 members. I am also a board member and two-time past President of the New Mexico Mental Health Counselors Association.

Clinical mental health counselors are primary mental health care providers who offer high-quality, comprehensive, integrative, cost-effective services across the life span of the individual. We are uniquely qualified licensed clinicians trying to provide mental health assessment, prevention, diagnosis and treatment.

I grew up in the welfare system with inadequate health insurance. Since the age of 18 years I have provided health care for patients. My career began as an enlisted member of the United States Air Force where I served for 20 years as a medic. As a clinical mental health counselor, I now see children, adults and families in a private practice in Albuquerque, New Mexico. My specialty is trauma.

Evidence all around demonstrates the Nation's mental health care system is in crisis. It is generating increasing demand for inpatient psychiatric beds while simultaneously decreasing its supply. Because patients have trouble accessing services in a community, they use the emergency department for basic and intermediate care. Our current mental health system still suffers from poor transition from inpatient institutions to community-based treatment.

In a recent scholarly article, Ms. Nalini Pande estimated that psychiatric boarding lost nearly \$4 million a year in revenue from service that could have been provided in lieu of boarding at just one 450-bed teaching hospital here. Ms. Pande also found that as patients waited, sometimes for hours, some for days, their psychiatric health deteriorated. Patients who often came in with manageable psychiatric illness subsequently turned into patients with acute needs.

But still, there is more than meets the eye. We at AMHCA believe some policymakers are going down the wrong path in addressing the problem of hospital boarding. The barrier to treatment is accessing timely, effective, quality mental health service in the community. Surmounting these barriers requires continuous comprehensive health insurance coverage that enables access to essential inpatient and outpatient care, prescription drugs, early intervention, and prevention programs. All of those essential benefits are provided in health plans governed by the Affordable Care Act

and new State Medicaid expansion programs, and some are available to Medicare beneficiaries as well.

We can work smarter to have a better health care system that systematically reduces crisis situations from developing. In addition to the importance of State Medicaid expansion, Medicare mental health services too have never been fully modernized to include newer providers like clinical mental health counselors and marriage and family therapists such as proposed by Representatives Chris Gibson and Mike Thompson in H.R. 3662. Comprehensive and stable health insurance coverage is the key to cost-effective, efficient, timely mental health services in the United States.

The new State Medicaid expansion effort has the potential for millions of currently uninsured Americans with mental health diagnoses to obtain greatly expanded access to mental health and substance use treatment in an integrated community-based setting with a person-centered treatment focus, the exact objectives, I believe, all policymakers are trying to achieve today.

Unfortunately, 25 States are refusing to participate in the new Medicaid expansion program, which will continue to leave millions of uninsured people with serious mental health conditions out in the coverage cold. AMHCA believes it is a huge and costly mistake that Congress under Medicare and State policymakers under Medicaid have decided to deny their most vulnerable citizens State health insurance coverage with comprehensive health care and mental health services.

In summary, Medicare and mental health provider coverage modernization and State Medicaid expansion will provide health insurance coverage to millions of people with serious mental health conditions who have had difficulty accessing needed and timely service. These changes are necessary to dramatically reduce the chances of future crisis situations and increasing emergency department visits.

Thank you again for the opportunity to present this testimony today before the committee.

[The prepared statement of Mr. Edgeron follows:]



Statement of Dr. LaMarr D. Edgerson, LMFT, NBCCH

Before the

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

On

**Where Have All the Patients Gone? Examining the
Psychiatric Bed Shortage**

March 26, 2014

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My name is Dr. LaMarr Edgerson and I wish to thank the Chairman and Ranking Member for the opportunity to testify today at this very important hearing on the psychiatric bed shortage. My doctorate is in psychology with a special focus in traumatic stress. I am a Clinical Mental Health Counselor, Licensed Marriage and Family Therapist and Board Certified Clinical Hypnotherapist. The population we are focusing on today is the population that I primarily serve.

Over the past year, I have served as Director at Large for the American Mental Health Counselors Association also known as AMHCA. I am here representing AMHCA's 7100 members. I am also a board member and past president of the New Mexico Mental Health Counselors Association. Clinical mental health counselors (CMHCs) are primary mental health providers who offer high quality, comprehensive, integrative, cost effective services across the lifespan. They are uniquely qualified licensed clinicians trained to provide mental health assessment, prevention, diagnosis, and treatment.

I grew up in the welfare system with inadequate insurance, but since the age of 18 years I have provided health care for patients. My career began as an enlisted member of the U.S. Air Force where I served for 20 years as a medic in the dental services area. I now see children, adults and families in a private practice in Albuquerque, New Mexico. My specialty is post-traumatic stress disorder.

I am very familiar with the inadequate mental health care system and the practice of boarding due to the lack of access to timely effective care. Evidence all around us demonstrates the nation's mental health care system is in crisis. It is

generating increased demand for inpatient psychiatric beds while simultaneously decreasing their supply.

Because patients have trouble accessing services in the community—including prevention, early screening, medication management and therapy—they use the emergency department for basic and intermediate care. Our current mental health system still suffers from, and is largely a reflection of, the poor transition from inpatient institutions to community-based treatment and the lack of funding for care.

I. Moderate and Severe Mental Health Conditions Can Turn into Crisis Situations

More people end up in emergency rooms, on the streets homeless, or in our nation's jails and prisons as their conditions worsen due to a lack of timely, needed mental health care services—or critically important follow up care.

Many people who need mental health services do not receive any treatment: Over 60 percent of adults with a diagnosable disorder do not receive mental health services, and nearly 90 percent of people with substance use disorder (SUD) do not receive specialty treatment for their problem. Individuals with lower incomes are more likely to have a mental health problem than those with higher incomes, and survey after survey indicates that cost is a major barrier to receiving care.

Many of the recent surveys on the use of mental health services indicate that public mental health delivery systems are in crisis—with increasing demand for inpatient psychiatric beds but a decreasing supply. Emergency Department (ED) directors report that psychiatric evaluation teams would not come to evaluate patients in the ED if there are no inpatient psychiatric beds available to place patients, further delaying definitive treatment. Because patients have trouble accessing services in the community—including prevention, early screening, medication management and therapy—they use the ED for basic, intermediate and crisis-related care. Our current mental health system still suffers from, and is largely a reflection of, the poor transition from state institutions to community-based treatment and the lack of local funding.

II. Psychiatric Boarding

Through the various roles I've held in mental health I am familiar with the practice of psychiatric boarding due to the lack of access to timely effective care.

A nationwide survey conducted by the American College of Physicians of more than 6,000 emergency departments, showed that 70 percent reported what is known as "boarding psychiatric patients" for hours or days, and 10 percent reported boarding persons with psychiatric conditions for several weeks.

The net effect of "boarding" is to reduce access to emergency department beds for those that are the victims of heart attacks, strokes, and auto accidents.

Reductions in mental health program spending during the recession came at a

price. The hardest hit initiatives are those providing mental health services to lower-income people and uninsured adults, many recently lost health insurance coverage in the recession. These consumers are often individuals who are ineligible for Medicaid and fall through coverage cracks.

Ironically, all of the cuts in mental health spending are adding costs to other service sectors and public agency budgets. Due to public mental health cuts, we are simply increasing emergency department costs, increasing acute care costs and adding to the caseloads in our criminal, juvenile justice and corrections systems. The unintended consequences of cutbacks including increased homelessness and unemployment take a devastating toll on other public agencies, and most importantly on our most vulnerable mental health consumers.

A terrible toll is emerging from the Iraq and Afghanistan wars that will be taken on our service members and we expect that various public agency budgets will be called upon to address the needs of many in this population who are unable to obtain services through the VA due to access problems. This is a pressure cooker preparing to explode. The current system is not designed, nor prepared to meet these significant needs.

We at AMHCA believe policymakers have been going down the wrong paths in addressing the problem of hospital boarding – a symptom of a larger problem. Make no mistake – the primary culprit behind this problem is not the Medicaid

inpatient psychiatric hospital exclusion, which is part of the access problem, as well as budget cuts and the reduction in psychiatric hospital beds.

No Mr. Chairman and members of the committee. The most significant barrier to accessing timely, effective, quality, mental health treatment is the lack of continuous health insurance coverage that provides comprehensive mental health benefits from inpatient care services to prescription drugs, to outpatient care, to prevention programs. All of those essential benefits are provided in health plans governed by the Affordable Care Act and new state Medicaid Expansion programs and some are available to Medicare beneficiaries.

III. Health Insurance is the Pass-Key to Timely and Consistent Care

We need to make sure that people with mental illness get the treatment they need at the onset of their symptoms, and after release from hospitals, jails, and prisons to prevent relapse.

Cutbacks in mental health care continue to occur despite the evidence that early treatment and prevention for mental illness and substance use programs is effective. Among many other benefits, effective and timely mental health services increase quality of life and productivity for people with mental illness.

When persons with mental health conditions or substance use disorders do not receive the proper treatment and supportive services they need, crisis situations often arise affecting individuals, families, schools, and communities. We need only follow the news to see the impact of improper care. Adequate health

insurance coverage can help people long before they find themselves in a crisis situation.

IV. New Medicaid Expansion Program and People with Serious Mental Health Conditions

The point of the Medicaid Expansion program is to treat people long before they need emergency department services. This can be accomplished via mental illness prevention, early screening and detection, as well as integrating primary care and mental health services for people suffering with several chronic conditions with the use of evidence-based care and treatment.

Continuous and stable health insurance coverage is the pass-key to cost-effective, efficient timely mental health services in the United States. All of us who have health insurance are fortunate that we have "better-sleep-at-night coverage" for our families. Unfortunately, not all Americans can say that.

This past December an article was printed in the George Washington University School of Medicine and Health Science. It was entitled, Innovations: Psychiatric Boarding – A Seven Pronged Approach to a Growing Problem by Ms. Nalini K. Pande. The article cited an important historical statistic that "the number of psychiatric beds plummeted from about 400,000 in 1970 to 50,000 in 2006. The movement to deinstitutionalize psychiatric patients has been partially offset by an increase of 50,000 additional private and general hospital psychiatric beds during this time," but clearly a large gap still remains in the treatment of America's

mentally ill. The article further cites a study, which estimates that “psychiatric boarding costs nearly four million dollars a year in lost revenue from service that could have been provided in lieu of boarding at ONE 450-bed teaching hospital.”

Ms. Pande states, “We shifted the focus to outpatient care, but the funding did not shift with it. With a lack of outpatient facilities to absorb psychiatric patients, these patients find themselves getting dropped off in an emergency department, because folks don’t know of another place to take them. As patients wait – some for hours, some for days – their psychiatric mental health starts to deteriorate. So, a patient who came in with a minor psychiatric illness subsequently turns into a patient with a major situation.”

AMHCA members know the burden of mental illness in the U.S. is significant due to increasing numbers of uninsured people with mental illness, as well as an underfunded mental health system. The new state Medicaid expansion program has the potential to achieve that goal for millions of currently uninsured Americans and specifically would afford people with mental health diagnoses greatly expanded access to mental health and substance use treatment in an integrated and community-based setting, with a person-centered treatment focus.

Unfortunately, 25 states are refusing to participate in the New Medicaid Expansion Program, which will continue to leave millions of uninsured persons with serious mental health conditions, out in the coverage cold.

Nearly 4.0 million of the 6.7 million uninsured people with a mental illness who are eligible for health insurance coverage through the Medicaid Expansion initiative will go uncovered because those 25 states are refusing to participate in the new Medicaid initiative.

In our recent report entitled, *Dashed Hopes, Broken Promises, More Despair: How the Lack of State Participation in the Medicaid Expansion Will Punish Americans With Mental Illness,* AMHCA details the drastic impact that living in a state without Medicaid Expansion has on health insurance coverage **for adults who have mental health conditions.**

Key findings from the AMHCA report include:

- Nearly 4 million uninsured people (3.7 million) who have a serious mental illness, are in serious psychological distress or who have a substance use disorder are eligible for health insurance coverage through the new Medicaid Expansion program in the 25 states that have rejected participation in the initiative.

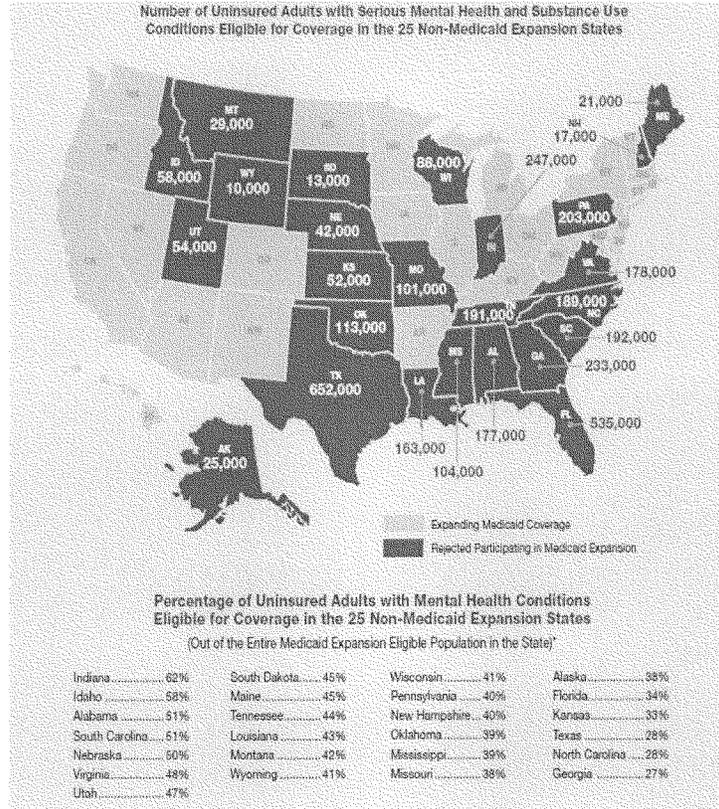
- Nearly 75 percent (2.7 million adults) of all uninsured persons with a mental health condition or substance use disorder who are eligible for coverage in the non-expansion states (3.7 million), reside in these 11 Southern states that have rejected the Medicaid Expansion: Alabama, Florida, Georgia, Louisiana, Mississippi, North Carolina, Oklahoma, South

Carolina, Tennessee, Texas and Virginia.

- More than 1.1 million uninsured people who have serious mental health and substance abuse conditions live in just two states — Texas (625,000) and Florida (535,000). These more than 1.1 million individuals are eligible for coverage under the new Medicaid Expansion program, but won't receive it. Since officials in Texas and Florida (and other 23 states) have said they will not participate in the initiative, they are leaving their most vulnerable citizens without health insurance, even though the federal government will pay for it at 100 percent for the first three years.

In the Dashed Hopes report, AMHCA projected the number of adults with mental health conditions who are eligible for coverage through the New Medicaid Expansion Program, under the Traditional Medicaid program, as well as through the new health insurance marketplaces.

The decision by state officials to not participate in the Medicaid Expansion means that these 25 "Left Behind States" are going to commit millions of their fellow citizens who are suffering with a mental illness—as well as millions more with chronic or serious conditions—to poor health, more poverty, and more despair.



The passage of the Affordable Care Act was a major milestone in long-standing efforts to ensure access for all Americans to appropriate, high-quality and affordable mental health care and prevention and treatment services.

Many of the most prominent features of the ACA were instrumental in establishing the **centrality** of overall mental health services within the overall

health care delivery system —such as the designation of mental health and addiction services as one of the ten categories of essential health benefits (EHB)

As originally conceived, this designation of essential health benefit provides for a comprehensive range of prevention and treatment services to be covered, including early identification and screening, early interventions, acute treatment, and chronic care management activities such as case management.

The early implementation of the Medicaid Expansion is already reshaping the delivery of services. For example, it is moving the field toward the integration of services with primary care, which has significant workforce implications in regard to team approaches, better coordination, as well as the new roles and responsibilities for staff. As screening for mental illness and substance abuse become more commonplace in primary care, more and more people will be identified as needing services.

V. Medicare Provider Access Must be Improved

AMHCA is very concerned with Medicare beneficiary access to outpatient mental health services. The Substance Abuse and Mental Health Services Administration and the Administration on Aging have documented the extent of behavioral health problems among older adults such as alcohol or medication misuse or abuse, depression, and anxiety. Behavioral health problems can have a great impact on older adults and are associated with decreased quality of life, diminished adherence to treatment plans, poor physical health, and overuse of

medical services. Despite the impact of behavioral health problems, they often go undiagnosed and undertreated. Older adults that do access behavioral health care often do so through primary care providers, and treatment is too often limited to administration of prescription medications. Furthermore, service providers are often poorly equipped to address behavioral health problems with co-occurring medical disorders, resulting from their inability to include appropriate providers in their practice arrangements, and insufficient physician time to screen, diagnose, and treat both physical and behavioral health problems.

Older Adult Mental Health Needs-- At least 5.6 million to 8 million older adults-- nearly one in five - have one or more mental health or substance use conditions which present unique challenges for their care. Unfortunately, fewer than 40% of older adults with mental and/or substance use disorders get treatment. Of those who receive treatment, most go initially to primary care physicians, who often cannot provide even minimally adequate care.

The single greatest statutory barrier that prevents Medicare beneficiaries from obtaining mental health and behavioral health care is the exclusion of Clinical Mental Health Counselors (CMHCs) and Marriage and Family Therapists (MFTs) from participating in the program. These two provider groups, which represent 40 percent of the licensed workforce, are fully qualified to deliver behavioral health services in all 50 states, but their services are not covered due to their more recent recognition for independent practice in the states. Other

federal agencies now recognize these two professions for independent practice, including the National Health Service Corps, the Department of Veterans' Affairs and DoD/TRICARE. It is long past time for Medicare beneficiaries to gain access to these providers to ensure they have access to necessary mental health services. Representatives Chris Gibson and Mike Thompson have sponsored legislation HR.3662 that adds CMHCs and MFTs) services under part B of the Medicare program and we urge you to act on this legislation.

Covered mental health professionals recognized by Medicare presently include psychiatrists, psychologists, psychiatric nurse specialists and clinical social workers. MFTs and CMHCs are not Medicare-covered providers despite the fact they have education, training and practice rights equivalent to or greater than existing covered providers. HR.3662 does not change the mental health benefit or modify the MFT/CMHC state scope of practice, but it will allow Medicare beneficiaries who need medically necessary covered mental health services to obtain these professionals' services. In essence, this bill only increases the pool of Medicare qualified providers that beneficiaries can choose from without changing the covered services.

Lack of Access in Rural and Underserved Areas--Approximately 77 million older adults live in 3,000 mental health professional shortage areas. Fully 50 percent of rural counties in America have no practicing psychiatrists, psychologists, or social workers. However, many of these mental health

professional shortage areas have CMHCs and MFTs whose services are underutilized due to lack of Medicare coverage. About 50 percent of rural counties have no practicing psychiatrists or psychologists. CMHCs and MFTs are often the only mental health providers in many communities, and yet they are not now recognized as covered providers within the Medicare program. These therapists have equivalent or greater training, education and practice rights as currently eligible provider groups that can bill for mental health services through Medicare.ⁱ

Medicare Inefficiency--Currently, Medicare is a very inefficient purchaser of mental health services. Inpatient psychiatric hospital utilization by elderly Medicare recipients is extraordinarily high when compared to psychiatric hospitalization rates for patients covered by Medicaid, VA, TRICARE, and private health insurance. One-third of these expensive inpatient placements are caused by clinical depression and addiction disorders that can be treated for much lower costs when detected and treated early through the outpatient mental health services of CMHCs.

Underserved Minority Populations--The United State Surgeon General noted in a report entitled *Mental Health: Culture, Race, and Ethnicity* that "striking disparities in access, quality, and availability of mental health services exist for racial and ethnic minority Americans." A critical result of this disparity is that minority communities bear a disproportionately high burden of disability from untreated or inadequately treated mental disorders.

Integration of behavioral and physical health care is key--Accountable Care Organizations and other initiatives that integrate physical and mental health care are demonstrating considerable health care cost reductions and quality improvements. Health care practices that provide integrated patient care can avoid unnecessary tests, provide integrated behavioral health and medical health diagnoses, and can readily prescribe psychiatric medications to support patient care. Most importantly, they report improved patient outcomes with lower costs. In many of these models, older adults receive screening and treatment for behavioral health problems in their primary care setting, and receive care from both their primary care provider and a behavioral health specialist that is co-located within the primary care team. Alternatively, some specialized behavioral health clinics and centers have embedded primary care practitioners within their practices to provide integrated care to patients. Effective integrated care teams develop a comprehensive plan to address physical and behavioral health care needs, and share patient care information. The behavioral health provider can support medication management prescribed by the primary care provider and can deliver brief evidence based behavioral health interventions, such as problem-solving therapy, interpersonal therapy, or brief alcohol interventions. The effectiveness of treatment is measured and tracked, and treatment is changed or intensified if a patient does not show improved clinical outcomes.

In the context of reforming Medicare, it is difficult to project greater cost effectiveness at significantly reduced costs than the concepts we have discussed. The nation has a proven resource in LMHCs and MFTs who are well qualified and dedicated behavioral health specialists.

VI. Opportunity to Re-Strengthen Mental Health Systems

Mr. Chairman, with the Medicaid Expansion program picking up the costs associated with uninsured people with mental illness, we have a unique and special opportunity to address one of the primary concerns that you have been highlighting in your hearings sponsored over the last year: Increasing access to mental health services by shoring up public mental health systems that have been essentially dismantled by state budget cuts,

Savings that accrue to states through the Medicaid Expansion could be funneled back in a way to re-strengthen state public programs especially at the community-level.

If a state chooses to opt out of the new Medicaid expansion initiative those State officials need to be fully informed about the potential problems their people will face while trying to access needed psychiatric inpatient care and community services. This potential perfect storm of budget and DSH cuts, coupled with a growing uninsured population with mental health conditions, and decreasing bed capacity, demands serious consideration and an immediate solution. The answer is for all states to participate in the New Medicaid Expansion Program.

Through the new Medicaid expansion, community mental health centers and other publicly supported community behavioral health providers would engage individuals earlier in the onset of their mental illness or substance abuse. It has been proven that early intervention and treatment result in better health outcomes at lower costs especially through programs that focus on high-cost Medicaid recipients with co-occurring mental illness and chronic medical conditions. With the federal government picking up most or all of the cost of Medicaid Expansion, the expense to individual states is low, making it even easier for states to opt in.

Although a few states are poised to spend additional "general revenue" funds to begin to reverse decades of underfunded programs, several states continue to propose budget cuts in mental health care. Despite the clear evidence that severe budget cuts have led to underfunded and inadequate services to address the needs of people with mental illnesses, states are simply turning their backs on their most vulnerable citizens. This is not the country America was designed to be, nor is it the country the world perceives us to be.

For reasons beyond my understanding our current mental health (and actually the overall health-care) system is designed to delay treatment until many individuals with severe mental health conditions become very sick and suffer serious consequences before treating them. Young people who show early signs of mental health disorders often do not receive treatment because of a lack of health insurance, stigma or simply because they lack information regarding what

they're suffering from or how receive proper assistance. Study after study, survey after survey, research after research, all show that delayed treatment is associated with incomplete and prolonged recovery.

VII. Connecting the Dots to a Better Mental Health System

In summary, please allow me to connect the dots.

The Medicaid Expansion will provide health insurance coverage to millions of people with serious mental health conditions who have had a difficult time accessing needed and timely services and reduce the chances dramatically of reaching a crisis situation.

Money that the states will save by transferring the costs of treating uninsured people with mental illness to the Medicaid Expansion effort can then be utilized to develop a strong infrastructure of community-based services that will decrease the need for inpatient beds in many cases. However, it should be known that the infrastructure in place today is inadequate in most, if not all, places.

AMHCA recognizes that a range of options for responding to youth and adults in crisis is needed, including mobile crisis teams, 24-hour crisis stabilization programs, and inpatient beds in community hospitals.

Many experts of our troubled mental health system agree: We must lessen reliance on costly and traumatizing crisis and inpatient care, and transition to a community-based model of care. The New Medicaid Expansion Program and

Medicare provider expansion will go a long way to getting us to the implementation and scaling up of that goal and model.

That is far more rational and humane approach than our current-crisis driven system which sends people to costly hospital ERs, overnight shelters and jails, ultimately causing psychiatric boarding and unending growth in emergency room budgets and corrections.

We can and must immediately begin the trek towards improving mental health services in our country; ensuring quality, safety and adequate oversight; and improving access to recovery-based care, especially the community.

The lives of these individuals, and many innocents, are on the line.

Mr. MURPHY. Thank you, Doctor. We appreciate that.
Dr. Evans, you are recognized for 5 minutes.

TESTIMONY OF ARTHUR C. EVANS, JR.

Mr. EVANS. Thank you. Mr. Chairman Dr. Murphy, Ranking Member Representative DeGette and members of the committee, thank you for inviting me to participate in this hearing. I am Dr. Arthur C. Evans, Jr., Commissioner of the Philadelphia Department of Behavioral Health and Intellectual disAbility Services, and I also have a faculty appointment at the University of Pennsylvania School of Medicine.

I appear here today on behalf of the American Psychological Association, which is the largest scientific and professional organization representing psychology.

As the Commissioner of the Department of Behavioral Health, my job is to ensure that the resources are deployed to address the needs of 1.5 million people in the city of Philadelphia.

So today what I wanted to do is to talk as an administrator, as someone who is trained as both a scientist and a practitioner, and also a family member myself, and I want to start by saying I think all of the issues that we have heard today are solvable problems. I absolutely believe that. I think we have evidence both in Philadelphia and around the country that all of the issues that we have heard today are solvable I think with political will, with resources and with leadership.

I really appreciate the family members who have testified today and especially Mr. Rahim, who gave his personal story, because I think that we have to hear that people can and do recover, and I want to start my comments by just giving a few examples of things that I think that we can do to improve the Nation's mental health systems.

First of all, people can and do recover, and we know from the research, we know from clinical practice that given the right resources, given the right types of services, people can do really well who have even the most serious forms of mental illness. Unfortunately, our systems are set up in a way that they don't acknowledge that. We have systems that are geared towards maintaining people, addressing people when they are in crisis, and you heard some of the stories of people who have family members who have a very difficult time getting help, and the reason that is, is because of the way we finance our mental health system. It is diagnostically driven. People either have to have a diagnosis or to be in crisis. So one of the first issues I think we have to take on is, how are we financing our services and are we doing things and are we financing our service system in such a way that we have the resources to do outreach and to do early intervention.

Secondly, I think that any discussion around psychiatric bed capacity has to deal with the efficiency of the current system. There are a number of things that we can do to improve the current efficiency, and I will give you a couple of examples from Philadelphia. We have in Philadelphia a unit that has people who historically would have been in the State hospital, very long lengths of stay, numbering sometimes in the months. We have employed evidence-based practices, both on the unit and in deploying ACT teams, or

Assertive Community Treatment teams, who have also been trained up in evidence-based practices, and we are starting to see a reduction in lengths of stay. I use that as an example because when we talk about increasing bed capacity and not addressing the inefficiencies in the current system, it is not a good use of our resources, and I think we have to take on those issues.

Similarly, we use a pay-for-performance system because we believe as a payer that it is really important to have accountability around the services that are provided. We have saved over \$4 million over a 2-year period simply by working with our inpatient treatment providers, focusing on things like continuity of care, making sure that when people are admitted that if they have a case manager that those people are coming onto the units, working with people so that there is a smooth transition. Those kinds of efficiencies can go a long way in increasing capacity.

I also believe that we have to have a public health strategy. We cannot simply have a treatment strategy around this. When people have difficulty getting into services, sometimes that is because people don't know how to navigate the system but often it is because there is stigma associated with mental illness that prevents people from reaching out for help and so part of our strategies have to be to reduce stigma and make it more likely for people to reach out for help. That is one of the reasons that we support things like mental health first-aid that help people to understand how to intervene.

Fourthly, I think that we have to think about cross-systems financing. Many of the issues—if you talk to mental health commissioners around the country and you ask them what are the top three issues, I would almost guarantee you that every single one of them would have housing as one of their top issues related to the administration of their system and so as we are talking about this, we have to think not only about services within the mental health system but we have to think about other services that people need to be successful.

So with that, I will stop and hopefully we will have questions that we can talk more about those.

[The prepared statement of Mr. Evans follows:]



**Statement
Of
Arthur C. Evans, Jr. PhD
Commissioner,
Department of Behavioral Health and Intellectual disAbility
Services,
Philadelphia, Pennsylvania**

**At a Hearing
"Where Have All the Patients Gone? Examining the Psychiatric
Bed Shortage"**

**U.S. House of Representatives Committee on Energy and
Commerce, Subcommittee on Oversight and Investigations**

March 26, 2014

Arthur C. Evans, Jr. PhD Testimony March 26, 2014

Mr. Chairman, Dr. Murphy, Ranking Member Representative DeGette, and members of the committee, thank you for inviting me to participate in this hearing. I am Dr. Arthur C. Evans, Jr. Commissioner of the Philadelphia, PA Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) and a faculty member of the University of Pennsylvania School of Medicine. I also appear on behalf of the American Psychological Association (APA) and the American Psychological Association Practice Organization. APA is the largest scientific and professional organization representing psychology in the United States and is the world's largest association of psychologists. Comprised of researchers, educators, clinicians, consultants, and students, APA works to advance psychology as a science, a profession, and as a means of promoting health, education, and human welfare.

As the Commissioner of a Department of Behavioral Health Services my job is to ensure that resources are deployed to address the needs of the 1.5 million people in the city of Philadelphia. This involves assessing the needs of individuals living in our communities and developing a comprehensive strategy to prevent, treat, and rehabilitate individuals with varied and diverse problems including serious mental illness and substance use.

The title of this hearing is posed as a question; my response to this question includes key points drawn from my experience as a Commissioner of a public behavioral health delivery system, a scientist, and as a clinician:

First, people can and do recover from mental health and substance use disorders. As the commissioner of one of the country's largest behavioral health systems, Philadelphia's, I know we can effectively help most of those who seek treatment, even for the most serious forms of mental illness, including schizophrenia and bipolar disorder. We have countless examples of

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people recovering and living fulfilling and productive lives in their communities. Recovery is facilitated when individuals live in an environment with the treatment and support services they need. With these appropriate community-based resources, more intensive interventions (such as inpatient hospitalization or outpatient commitment) are less necessary. It is counterintuitive that the solution to a perceived inpatient bed shortage is to build a strong community-based service system. But, experience consistently shows this to be the case. An over emphasis on inpatient beds can drain needed resources away from the very services that prevent people from needing crisis services. Service systems that have good inpatient service capacity and inadequate community resources create a climate of unnecessary hospital admissions and repeated crises that reduce the likelihood that both adults and children can achieve stability and health.

We know that the onset of serious mental illness typically occurs in the late teens and early twenties. Symptoms of serious mental illness often emerge slowly over this period and can be difficult to detect, and, what is most challenging, those who are experiencing behavioral health issues may not recognize their need for treatment. It is not that we do not know how to treat these individuals, but that too often, we are not given the chance. Usually the lack of treatment this causes distress that individuals and families experience in isolation; and can, in some cases, lead to public tragedies.

However, when we focus on those individuals in acute distress who need inpatient care we are taking a snapshot of their illness at only one point in time – we are not seeing the history of the development of their illness, and, we are not focusing on the multiple missed opportunities to intervene and heal. As we seek answers to improving our mental health system, we need to

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reframe our questions to: “What are the needs of people in psychiatric crises?” and, even more importantly, “How can we prevent these acute crises?”

Second, we need a comprehensive strategy for people in crisis across their lifespan and within their communities. We cannot wait for the illness to emerge or move from crisis to crisis, so this strategy must include as a first step comprehensive programs for prevention and early intervention. Prevention and early intervention are more efficient than a singular focus on treatment. Further, instead of just an individual focus, we need to focus on community level interventions – increasing understanding of mental health issues, reducing environmental stressors such as violence and trauma, increasing safe and healthy housing, developing employment opportunities, and decreasing misperceptions of mental illness that prevent people from seeking out help when needed.

As an example, Philadelphia is undertaking a public health approach that utilizes several low-cost and potentially high-impact initiatives that focus on early intervention. One of the most promising—Mental Health First Aid—is a program that teaches the public the basics of identifying behavioral health issues, supporting individuals experiencing symptoms and connecting them to needed services. The goal is to increase the community's ability to recognize these issues and to give them the confidence to assist relatives, friends, coworkers, and others who may be experiencing psychological distress. Philadelphia's program is perhaps the most ambitious in the country, with a target of training ten thousand citizens in the next two years, including teachers, first responders, parents, law enforcement, faith communities and others. So far, the enthusiastic public response has shown a thirst for this kind of information. We have collaborated with the Philadelphia Police Department and since 2006

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we have trained 1600 law enforcement personnel in crisis intervention. This program is designed to reduce conflict and escalation between law enforcement and individuals with serious mental illness. In addition, my department has expanded its early intervention capacity by launching an online screening resource that can help detect mental health issues early and recommend ways to get help. If we focused our resources on early intervention and outreach programs, we would reduce the need for inpatient settings.

Third, it is crucial that our behavioral health systems rethink their current means of assessing the number of needed inpatient beds. From my experience developing and managing a comprehensive mental health delivery system, it is clear to me that the need for inpatient beds is driven by the scope of outpatient and community-based resources that exist in the community. This is very different from most existing modes of assessment that focus primarily on the size of the population and thus, may leave some areas with inadequate services.

Community-based outpatient treatment and support services can prevent the need for inpatient services; communities differ dramatically in these resources. Outpatient resources and support services are part of any equation to understand the drivers of the utilization of inpatient psychiatric treatment. These community-based resources include intensive outpatient therapy, partial hospital services, intensive case management, assertive community treatment, and other community support systems, such as safe housing, employment opportunities, family education and support such as respite care. A system with comprehensive community services will have less need for inpatient beds as compared to a community without such services. By increasing these resources and improving their linkages to one another, we can

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decrease the need for inpatient hospitalization and improve long-term outcomes for people experiencing a mental health crisis.

Fourth, we need to develop post-inpatient treatment approaches and strategies that help to stabilize people and permit them to develop the skills they need to function in the community. These types of community resources reduce the need for crisis-driven services and inpatient psychiatric settings. For instance, one research finding is that employment is a stabilizing force in an individual's lives. By focusing on providing education, training, and other services that support employment those with serious mental illness and substance use problems can successfully reintegrate into the community and build a better life for themselves and their families.

In Pennsylvania we are investing in programs that build optimism, confidence, and skills in individuals with serious mental illness. In 2006, the Commonwealth started a statewide Certified Peer Specialist (CPS) Initiative. As a result of this initiative, people who were once relegated to the status of passive, long-term behavioral health care recipients are now being trained and then hired to support and motivate their peers. These positions are competitively paid, full or part-time jobs that enable Peer Specialists to serve as models of recovery for behavioral health program staff and participants and to serve as uniquely effective advocates. Philadelphia has succeeded in recruiting and training over 580 Certified Peer Specialists since the inception of this initiative. Out of the 580 trained, the Mental Health Association reports approximately 60% have gained employment in a variety of employment settings. Our own community-based treatment programs hire the majority of Certified Peer Specialists in practically every clinical setting in our service system including residential settings, outpatient

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programs, free standing support programs and inpatient psychiatric hospitals. Of particular note is that peer specialist are now being deployed in the city's network of crisis response centers which are designed to assess individuals who are in psychiatric crisis and connect them to the appropriate treatment service. Peer specialist in these settings play an important stabilizing role for individuals and provide a critical factor for people in crisis - hope that things will get better.

The introduction of peer specialists into our service system has been one of the most important factors in improving service delivery and outcomes for people with serious mental illness and substance use problems. For example, incorporation of peer specialist into our network of specialized services for people with serious mental illness has resulted in a decrease in crisis response center utilization, and an increase in community activity. We also have self-reports of an increase in positive connections with family members, friends, and community partners, increased confidence and hopefulness and an increase in education and employment. In order to fund this initiative, the Commonwealth was successful in rewriting the State Medicaid plan that allowed Pennsylvania to pay for peer support services for individuals with serious mental illness using Medicaid dollars. Access to Medicaid funding allowed Philadelphia and other counties to implement and progressively expand this important resource.

New initiatives we are investing in are Recovery Wellness Community Centers (RWCCs). These centers will provide holistic wellness services to individuals (their families and significant others as well) in recovery from, or seeking to recover from, substance use disorders and/or serious mental illness. The RWCC is to be community driven, designed, implemented and then run by the community in which it is located. It is expected to offer the

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services which people of the community want and need to strengthen both their personal recovery and that of their community. Our experience has shown that these kinds of resources are critical for helping improve people's integration into the community and decreasing the need for acute hospitalizations.

Fifth, initiatives to address psychiatric inpatient bed capacity should include efforts to improve the efficiency of existing resources, while using data-driven approaches to inform practice and policy. Fortunately, we are at a point where our scientific advances have demonstrated effectiveness with the most serious behavioral health conditions, including serious mental illness. For example, in Philadelphia, we have utilized evidence-based treatment approaches to shorten lengths of stay for individuals who have historically had very long hospitalizations. Additionally, working with our inpatient providers, my department has implemented a pay-for-performance system for the past six years which has resulted in practice improvement and system efficiencies. This data-driven approach has reduced readmissions, as well as improved continuity of care. These improvements have resulted in more capacity, financial savings in excess of \$4 million over 2 years, and most importantly, better clinical outcomes for people receiving these services.

Sixth, finally, we must address the perverse financial incentives in our mental health systems. Currently, our systems are diagnostically driven and crisis oriented. Typically, in most systems it is nearly impossible to get help if one does not have a diagnosis or is not in psychiatric crisis. Because of this, systems are almost entirely reactive, as almost all of their resources are devoted to treatment after the fact, with minimal resources available for engaging people prior to a crisis. This means funding agencies like mine typically devote less than 3% of their

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budgets to prevention and early intervention. That leaves families and communities to fend for themselves when it comes to identifying those who need help and then navigating the system to get it.

Flexibility of our payment system for behavioral health is essential. Our behavioral health system needs more resources focused on broad-based outreach, prevention, early intervention and engagement for individuals and their families. We know that early intervention can dramatically improve the trajectory of mental illness and recovery. Behavioral health systems across the country need more flexibility to fund these "upstream" activities. I believe we should be spending at least a third of our budgets on prevention and early-intervention services.

In conclusion, no discussion of the needs of those in with serious mental illness and substance use problems should focus solely on increasing inpatient beds or lowering the threshold for commitment without addressing the need for a comprehensive, culturally appropriate strategy to promote mental health and prevent behavioral health disorders across the lifespan. We must use the latest scientific evidence and management strategies such as pay-for-performance to get the most efficient use of resources. We must also broaden our range of services beyond the health care system to build on strategic local partnerships to build community resources necessary to respond and heal - for instance, training our first responders, partnering with community organizations and faith-based groups, and investing in our children and youth to support healthy starts to their lives. Most importantly we must become effective allies of families - giving them the tools they need to raise healthy children

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and then providing them with comprehensive services and supports when they turn to us for help when in need.

Mr. MURPHY. Thank you, Dr. Evans. As we go into comments here, or questions from Members of Congress, I just want to have a special thank you for this panel. We have had a number of hearings and panels on this issue of mental health, and I recognize members have very busy lives and some are at other hearings and other areas, but for those members who missed your testimony, I think their lives are the poorer for it, and to watch how someone would walk through the system is pretty difficult. So let me recognize myself for 5 minutes.

Ms. Ashley, your experience you related to us in your testimony concerning your son's admission and boarding in a local ER from hours to days, I mean, it is alarming to us. So were there any other places in the area, were you informed of any other place in the area where you could have taken your son instead of having those long delays in the hospital?

Ms. ASHLEY. You mean another emergency room?

Mr. MURPHY. Yes.

Ms. ASHLEY. Well, my insurance only pays for the hospital that we went to.

Mr. MURPHY. OK. And Dr. Hirshon, in this case, and we had heard this also, for example, on 60 Minutes when State Senator Creigh Deeds was talking about his own son, he couldn't find a place. Is that part of the problem that occurs too with emergency rooms in terms of getting someone to—

Mr. HIRSHON. Yes, the issue of finding an inpatient facility can be very problematic. You have to find a place that is going to accept that patient, and historically, there may have been insurance issues as well. And so, in Maryland we have tried to devise mechanisms to improve this. One of the things we have now is kind of a central listing of the hospitals that have inpatient facilities, that have beds available, but even that is problematic getting the hospitals to buy into it. So this is a traditional problem, especially if you have someone who has got a dual diagnosis. Perhaps they are an adolescent with bipolar and maybe substance abuse. They can wait—I have had friends had patients wait for 13 days in their emergency department looking for a place to stay.

Mr. MURPHY. Thank you.

Sheriff Dart, any idea what your total costs per year in dealing with folks with mental illness in your jail are?

Sheriff DART. You know, Mr. Chairman, that has always been a difficult number for us to ascertain, but just as a rule of thumb, it is in the ballpark clearly double, closer to triple the cost of an average detainee, so we are talking just tripling every expense that we have there, but the difficulty where it gets to be sort of quantifying this is that they come back to us so quickly. So it isn't even as if you took the one detainee and said OK, he cost more than the other ones and—

Mr. MURPHY. You are talking about some of those costs, \$12,000 for pretrial costs and other things with that. Now, is any of this federal money that is used to help these patients, these inmates while they are there?

Sheriff DART. No, no, virtually none. It is all county-related money.

Mr. MURPHY. OK. Let me ask also, in this past winter, I heard about a homeless man who had mental illness in Washington, D.C., couldn't take him in because it was only 32 degrees. But once the temperature hit zero, it would be OK. Is that true, this story that I heard, Mr. Stern?

Mr. STERN. Actually, I think Washington did sort of a heroic job over past years. They had buses, metro buses out when it got, I think below 15 degrees, and there was hypothermia in effect under 32 degrees.

Mr. MURPHY. When I look upon this, and we talk about somebody being—we are not going to provide help until there is a crisis, they threaten to kill someone, themselves, or you had talked about people who are not even aware of their symptoms. In this case, now they are an imminent threat because they are not even aware of their illness. It is sad that we have to go to that extent.

Mr. STERN. Yes. I mean, the one thing that I would say is, on the day it got really cold, I went out to the bus, and there were three people on the bus. I then went under a bridge nearby and there were five or six people there who refused to go on the bus, so there is that.

Mr. MURPHY. Thank you.

Dr. Evans, as you heard these stories about how much is spent—Judge Leifman talked about this, Sheriff Dart talked about this, Chief Biasotti, all these other folks. If you had that kind of money, could you make a difference? I mean, we are spending it in hospital beds and emergency rooms where they are not getting treatment. We are spending it in jails. We are spending it in courts. Could you keep people out of those systems if Medicaid and other things paid for that kind of thing?

Mr. EVANS. There is no question that we can and we do. For example, in Philadelphia, take the issue of homelessness. Because we have a mayor that has been pretty interested in this issue, he has been able to convince the Philadelphia Housing Authority to make available Section 8 vouchers to my department, which does homeless outreach. Over the last several years, we have had approximately 200 vouchers a year, and with that, we have been able to get over 500 people off of the streets of Philadelphia who were formerly homeless, many of whom have serious mental illness and/or substance use problems, and the way we were able to do that is to use those housing resources matched with Medicaid-funded behavioral health care services, and to date we have about 93 percent of those people are still in stable housing. So I think that these are solvable issues. I think it takes creative financing and I think it takes innovations in how we deliver services.

Mr. MURPHY. We look forward to hearing some specific comments from you and others too on what needs to change in some of the definitions of care so that money can be spent in helping people, preventing problems and treating them.

I have to ask you, Mr. Rahim, because you have Ms. Ashley at the table here, who has a son who is a good man but dealing with schizophrenia, do you have advice for parents and for other people dealing with this?

Mr. RAHIM. I believe that Dr. Evans said it best, that mental illness is treatable and I think a lot of the panel said mental illness

is treatable but I think we have to have the education to know that it is treatable and that it is something that you can overcome, and I think having faced this as well as evidence-based practices will do so much.

Mr. MURPHY. Thank you. That is a good message of hope.

Ms. DeGette.

Ms. DEGETTE. Thank you. Let me follow up on that statement, Mr. Rahim, by you and Dr. Evans.

Dr. Evans, you talked about how evidence-based practices and lengths of stay can really be used for treatment, and part of the problem, part of some of these illnesses is people don't realize that they are ill, and part of it is stigma. So my question to you is, from what I understand from what you are saying and others, is that if we can identify someone with severe mental illness early on and get them into that treatment, we actually can stabilize their situation. Is that correct?

Mr. EVANS. That is absolutely correct, and the research is pretty clear on this. If you can intervene with people early, particularly after their first episode, and there are evidence-based treatments for people who are experiencing their first episode, you can dramatically change the trajectory of their illness and significantly improve clinical outcomes.

Ms. DEGETTE. And I would assume you would agree with me that probably the way to do that early identification is not when they present in an emergency room or a jail, correct?

Mr. EVANS. That would be correct.

Ms. DEGETTE. And I would assume, Dr. Hirshon, you would agree with that from an emergency room perspective as well. That is not the ideal way to identify a severe mental illness and treat it, correct?

Dr. HIRSHON. We take care of emergent and urgent, you know, acute psychiatric problems but my preference would be not to have to deal with that, I mean, to find support systems, both inpatient and outpatient, that they don't come at 3 o'clock in the morning homeless and cold because they have no other place to go, and so yes, I would—

Ms. DEGETTE. And have to find a bed.

And Mr. Dart, you would agree with that from a penal perspective as well, correct?

Sheriff DART. Oh, absolutely, on two fronts. One, frankly, during the cold weather, we have people affirmatively commit offenses so they can come into our housing. I talk with the detainees on a regular basis. They will tell me frequently they don't want to leave the jail because it is the best place they can go for treatment, they feel safe, they don't get harmed out in the community, and we have had some where when we release them, they will try to break back into the jail as a result of that, and Congresswoman, the one thing that always has troubled me, when you think about it, each and every one of these people, we have a full file on them, not only on their criminal background but their mental health needs. Why we can't follow them out in simple case management type of fashion, and even if we just break the cycle for a short period of time, we would save tremendous amounts of money.

Ms. DEGETTE. You don't know this, Sheriff, but I started my career as a public defender, and so I know this very, very well. I had so many clients in those days who you could just see they were severely mentally ill, and there was nothing we could do with them.

Now, I want to ask you again, Dr. Hirshon, I mean, if we had a better system like one Dr. Evans is talking about to identify and to treat folks at an early stage, then when somebody really did have an acute problem, the emergency system would be better equipped to deal with those folks because theoretically, there would be fewer of them, correct?

Dr. HIRSHON. Well, there would be fewer but there would also be more structure to support them. So a lot of this is the lack of a kind of systematic structure to support these people who are either coming in because they have acute needs or because of their social circumstances. So the idea to have that improved structure both from a mental as well as social perspective I think is very critical.

Ms. DEGETTE. Yes, and I want to ask you, Ms. Ashley, as a fellow mom here, you would much rather—you, as a nurse, identified that your son had severe psychiatric problems from an early stage but you didn't have any recourse to get him the kind of treatment he needed except for continually taking him to the emergency room. Is that what I heard you saying?

Ms. ASHLEY. Yes, that is right. I worked very closely with his primary medical provider, who obviously knew there was something wrong with him, but my son would continuously deny going to the emergency room to get psychiatric evaluation. The psychiatric people were even willing to come to his medical appointment to evaluate him. That is how tight our community was. And still my son would say no, he would not go. So I actually had to set up a situation where he went to the emergency room to get lab work done and then have him received by the psychiatrist and his primary medical provider to put him on a hold.

Ms. DEGETTE. Thank you.

Now, Dr. Evans, just if you can briefly tell me, you have got several projects going on. Where do you get the funding for those projects?

Mr. EVANS. So Philadelphia is unique in that the city manages all of the public sector behavioral health services that come in. The city is capitated for the entire Medicaid population so we manage the Medicaid benefit for everyone who has—

Ms. DEGETTE. So you are getting Medicaid benefits?

Mr. EVANS. They are getting Medicaid, but we also receive State, federal, local grant dollars as well.

Ms. DEGETTE. And I just want to finish up with you, Mr. Rahim. You heard what Ms. Ashley was talking about. Her son was denying what was happening and she had to sort of trick him. What do you think about people who get diagnosed with these diseases? Is it the stigma? Is it the nature of the disease? And what is your opinion what we can do to get folks into treatment like you were able to do and to accept the disease, very briefly?

Mr. RAHIM. So, I have to very much recognize that mental illness is individual to each person. There are so many different diagnoses, and each person, even with the same diagnosis, responds differently to the medication, responds differently to the knowledge

that they may even have it, or even responds differently to their parents' care and concern. So I mean, with that—and I do want to acknowledge that. I am a voice but I am not the only voice, and there are so many people out there, so I just want to acknowledge that to your point, that is, it is so different, and it is hard. This is hard, you know, this is not easy. So even if you have the care provided, it is still a journey, one, and two, you still have to recognize that everybody is different.

Ms. DEGETTE. Thank you. Thank you very much, Mr. Chairman.

Mr. MURPHY. Thank you. I now recognize the vice chair of the full committee from Tennessee, Mrs. Blackburn, for 5 minutes.

Mrs. BLACKBURN. Thank you, Mr. Chairman.

I want to thank each of you for taking the time to be here and for your willingness to tell your stories, and I think it is such an important component, and it is important for us to have your insights as we look at the issue. The chairman has been on this since day one, and looking for a way to reach parity and to provide some certainty for those that suffer from mental illness. So we appreciate that you are helping us work through this process.

Dr. Hirshon, I want to come to you first. Going back to the American College of Emergency Physicians 2014 State by State report card that is out there, and looking at the data relative to 5 years earlier, and you look at the declines in the psychiatric beds across the country. Has that been consistent in your rural, suburban and urban issues? Where are we seeing the greatest attrition in the number of beds? Because one of the things we hear from people, especially in our rural areas, is, they have no access and they don't know where to turn.

Dr. HIRSHON. So I would say that each jurisdiction, each region, each State is different. It is a little hard to say. But as a general rule, access to care in rural settings is much more difficult. And the other thing to recognize is that even if you have insurance, insurance doesn't mean access because you have to find someone who can take that insurance and who will be there to give you the services. So as a general rule, the rural settings and the areas in which there are fewer services are disproportionately impacted. So I would agree with that.

Mrs. BLACKBURN. OK. How do we fix that? How do we fix that disparity? What do you think? Because the access is so critical, and as you said, you may have access to the queue but that does not mean you have access to the physician, and what we are seeing with the implementation of Obamacare, the President's health care law. So many people say well, I have got an insurance card now, and of course, in Tennessee, we saw this with the advent of TennCare back in the 1990s but there was nowhere that they could go for the care or it may be 180 miles away, which is debilitating when you are trying to access this. So what do you think?

Dr. HIRSHON. I think again that, you know, not just psychiatric care but many types of care, you have to look for creative solutions, and one of the solutions for that is regionalization of care. So for example, if you have got a regional center of excellence for psychiatric care, to be able to utilize that either through telemedicine so they can do evaluations long distance or in a setting in which they don't have a psychiatric provider there or there is a way that

you can use that regionalization to help improve the care I think is one potential model. I think we need to do research to look for better ways to be able to provide care, recognizing that our technology—there is an increased demand but our ability to perhaps meet that demand can be adjusted.

Mrs. BLACKBURN. OK.

Ms. Ashley, I see you shaking your head. You like the idea of using the telemedicine concepts?

Ms. ASHLEY. Yes. At UC Davis, we already use telemedicine for medical diagnoses and so forth, and so I definitely can see telemedicine with good case management follow-up definitely would be very helpful to the family and the consumer.

Mrs. BLACKBURN. So would you classify that primarily as using the telemedicine concept as an assistance in early intervention or where would that have the greatest impact?

Ms. ASHLEY. At the very beginning.

Mrs. BLACKBURN. The very beginning, being able to utilize that.

I have just a couple of seconds left. Dr. Geller, deinstitutionalization, and you talked about that in your testimony and you said it was not initiated as a considered policy but as an accident of history. I want you to expand on that for just a moment.

Dr. GELLER. Sure. If you look at the literature throughout the era, you don't find any literature that talks about deinstitutionalization before it happened. It was labeled retrospectively. Some of the downsizing occurred because of the introduction of psychotropic medications, and some because of advocacy. But the major incentive for deinstitutionalization is the IMD rule. The IMD exclusion means that if I am in a State hospital, my State pays dollar for dollar for my care. If I am in a community, my State pays no more than 50 cents on the dollar and may pay as little as 13 cents on the dollar. So that any State has a vested interest in moving people from State hospitals to the community, the cost shift from State tax dollars to federal tax dollars, and I believe that has been the major incentive. It was never designed policy.

Mrs. BLACKBURN. So it was done for the money.

I yield back.

Mr. MURPHY. Thank you. I now recognize Mr. Butterfield for 5 minutes.

Mr. BUTTERFIELD. Thank you very much, Mr. Chairman, for convening this hearing, and thank all of the witnesses for your testimony today, but more importantly, thank you for your passion. I understand what mental health is all about, and I thank you so very much.

I missed some of your testimony but I have been reading as quickly as I could. Dr. Edgerson's testimony, I have it in my hand, and it is very interesting and it is very correct. You dwell on the Medicaid expansion aspect of health care, and I thank you for raising that because that is critically important. As most of us know, this committee wrote the Affordable Care Act. It was written several years ago, and the Energy and Commerce Committee is the proud author of that legislation, and as part of that legislation, it was our intent to expand the Medicaid provision so that low-income, childless adults could receive the benefit of health care. We mandated that the States expand their program, and that part of

the law was tested in the U.S. Supreme Court, and unfortunately, the Court said that we overstepped our authority, and even though it was a proper exercise of legislation that we could not compel the States to expand their Medicaid program, and that was very disappointing to me. And now 25 States have refused to participate in that expansion, and my State of North Carolina happens to be one of those States. My State turns down nearly \$5 million per day which could help provide care to those with mental health issues, and so I am appalled, not only appalled at my State but the other States that have chosen not to expand their Medicaid program because we need it.

The Medicaid expansion would not have been a cost to the States, at least for the first 3 years. All of the costs would be borne by the Federal Government. Following that, the Federal Government would pay 90 percent of the cost of care, and so we have low-income individuals all across the country who are suffering from mental health issues, from substance abuse who are not getting the care that they rightfully deserve.

I live in a low-income community. It is an African American community in North Carolina, and I can tell you that mental health and substance abuse issues are pervasive all across my community. Before coming to Congress 10 years ago, I was a trial judge, not only in my community but in 32 counties throughout my region. I was one of 10 judges who presided over the most serious cases in 32 counties, and I can tell you that we need to extend a hand of friendship and a safety net for those who are in need. And so I applaud you for lifting up the whole idea of Medicaid expansion.

Now I get to the question, Dr. Edgeron. I had to get that off my chest because I understand mental health, not as much as the 10 of you, but I clearly understand it. I understand the cost of not treating and detecting mental health issues, and I know that we would be a better nation if we just slowed down long enough to recognize the importance of this issue, and while I am on that, Mr. Chairman, I want to thank you. I think Ms. Blackburn was correct, that you have lifted this issue up as a priority of yours from day one, and I thank you for it.

Dr. Edgeron, it is estimated that 189,000 people in my State with mental illness would be eligible for Medicaid if my State would expand Medicaid. How many of the individuals presenting in the emergency rooms with psychiatric and psychological issues would have avoided an emergency room visit if Medicaid had been expanded and they were able to seek treatment before their disease became a crisis?

Mr. EDGERSON. I cannot give you an exact number. However, what generally happens is, if there is not one thing that we know, we know we can go to the emergency department if we are having any kind of crisis. A lot of people do not necessarily have to go to an emergency department because the crisis can be averted in the beginning, and this is where I believe that clinical mental health counselors and marriage and family therapists can come in. So while I may not know that I have a mental health issue, my friend or my family member may know, and they may be able to convince me or persuade me, hey, why don't you go and talk to this person here and maybe we can help you out, and for me, that is where

the beginning steps are because once I create the relationship with that patient or client, then they are less likely to go into a crisis scenario and end up in an emergency department.

Mr. BUTTERFIELD. Thank you.

My next question is to you, Mr. Dart, and I heard some of your testimony earlier, and you talked about some people believe that jail is the best place for treatment, and you are absolutely correct. Some in the audience or some watching on television may find that incomprehensible but that is a fact in real life.

When I was a trial judge, people would inappropriately—they didn't know they were being inappropriate—they would call me at home the night before their loved one was to be sentenced and they knew that the next day the loved one would probably be getting out of jail and returning to the community, and families would literally call me and beg me—many of them knew me personally. We had grown up together years ago. They would call and plead with me as a judge not to release their loved one because they could get better care and treatment in the facility as opposed to the community, and they felt that releasing their loved one would be a danger to the inmate and to the community. So thank you for bringing that up and reminding me of those days when I was on the bench.

You have been very kind, Mr. Chairman. Thank you very much. I yield back.

Mr. MURPHY. I now recognized the vice chair of the subcommittee, Dr. Burgess, for 5 minutes.

Mr. BURGESS. Thank you, Mr. Chairman.

Mr. Rahim, I just have to say, I don't think it was part of your prepared remarks but your comments about the individualization of care and the personalization of care, those words are golden and I hope that everyone on this dais heard those and will consider them.

Dr. Geller, thank you for your thoughtful chronicling of the problem. I cannot go back as far as Franklin Pierce but I did practice medicine in the 1980s and 1990s, not psychiatry but more in the general medicine realm, but I remember during that time the vast expansion of psychiatric facilities that occurred. I am not sure if I know why that expansion occurred but then as a result of probably actions by perhaps this subcommittee in April of 1992, a lot of that was curtailed, and in fact, just researching for this hearing, there is an article from 1993 that talked about in one 4-year period the number of psychiatric institutions doubled, and the graphic they have is 1984 to 1988. This was a major scandal in the country. A company known then as National Medical Enterprises eventually entered into some sort of consent decree with the Department of Justice and many of the private insurers sued the hospital company for overutilization or overhospitalization of patients.

So it seems like we went from there where there was too much activity going on to now where there is not enough. I can't help but feel the emphasis on administrative pricing and not paying attention to the individual care that Mr. Rahim talked about is perhaps responsible, but I think this subcommittee would do well to remember that it was 20 years ago where we were talking about a very different problem. You were probably—I don't want to presuppose, but you were probably in practice at that time. Is that correct?

Dr. GELLER. Yes, sir.

Mr. BURGESS. Do you recall the events that I am talking about?

Dr. GELLER. Yes, sir.

Mr. BURGESS. And what is your observation? I mean, help us here. You were there, a psychiatrist on the ground, when this was going on. In your opinion, what is it that happened that caused that rapid expansion of psychiatric meds and their overutilization and then the contraction that followed?

Dr. GELLER. The expansion that you are talking about was largely accounted for by private psychiatric hospitals, generally chain hospitals, that saw an opportunity to make money quickly. When managed care began to require pre authorization and the possibilities for admission became more stringent, those hospitals quickly disappeared. While all that is happening, the public psychiatric hospitals were still shrinking, and if I could take a moment?

Mr. BURGESS. Sure.

Dr. GELLER. What we seem to not be spending time on is that we are talking about psychiatric disorders, and while resources are necessary, "build it and they will come" does not apply to all the people who have psychiatric disorders. We had a demonstration of that in western Massachusetts. We had a federal court-ordered consent decree in 1978. Western Massachusetts, the catchment area, is larger than five of the States in the United States. At that time western Massachusetts had more per capita expenditure for mental health services than any State in the United States and there wasn't another State that came close. And we still had some of the same problems.

Mr. BURGESS. Yes, sir.

Dr. GELLER. We have a population, some of whom have something called anosognosia. They don't recognize they have an illness. You need more than just resources.

Mr. BURGESS. Let me ask you, Dr. Hirshon, in the few seconds I have left. I mean, you bought up EMTALA, and as a practicing physician, I am familiar with that. One of the great venerable institutions in my neck of the woods, Parkland Hospital, got into a great deal of difficulty with their psychiatric emergency room not too terribly long ago, in fact, put the whole institution at risk because of some federal regulations that they ran afoul of, but eventually they went to outsourcing their psychiatric emergency room to a private hospital facility. In your experience, does it seem like more hospitals are going to be doing this?

Dr. HIRSHON. My sense is that it is more complicated than simply a single answer. You have to look at it from both the patient's perspective as well as the provider's perspective, and coming up with solutions that allow you to meet the patient's needs. If it is outsourced in one jurisdiction, that might work, but again, I think recognizing that there is a limited number of resources, looking for ways to more efficiently and effectively utilize those resources will be key.

Mr. BURGESS. Thank you, Mr. Chairman. I will yield back.

Mr. MURPHY. Thank you. The doctor yields back.

Mr. Tonko, you are recognized for 5 minutes.

Mr. TONKO. Thank you, Mr. Chair, and I appreciate your continued use of this subcommittee to shed light on the issues related to

mental health. For far too long now, mental health issues have been swept away in the shadows, so anything we can do to raise the profile and reduce the stigma associated with mental illnesses is a very worthy endeavor indeed.

As amply demonstrated today, the lack of available psychiatric beds, particularly in times of crises, can be a pressing issue. For example, we all witnessed the tragedy that occurred in neighboring Virginia when State Senator Creigh Deeds was unable to locate an available bed for his son in time. However, we also all share a goal of deescalating in treating these types of situations before they do reach the stage where a patient requires hospital-based care.

So with that in mind, Dr. Evans, from your experience, how can we improve our mental health delivery system in a way that reduces the demand factor for inpatient psychiatric care?

Mr. EVANS. Thank you for that question. I think that, you know, any discussion about psychiatric bed capacity focuses on expanding bed capacity, and I think that is a trap. Prior to being in Philadelphia, I was also the Deputy Commissioner in the State of Connecticut, so the past 15 years I have been in administrative positions that have to make decisions about how resources are deployed in a mental health system, and I can tell you that the fundamental issue is that we have to build a very strong community-based system. That is the fundamental problem. Psychiatric bed capacity is only a symptom of a deeper problem, and I think you hear the testimony of all the people here, they talk about the difficulty when it is clear that a family member or even a person is having a problem. Well, there are not the resources to do the kind of outreach to individuals when they are at that point, and the way we finance our service system, we have to wait until people are at a crisis point, and you know, that is not only the problem of the mental health systems but it really has to do with the fact that unless we create the kind of flexibility where mental health systems can do the kind of assertive outreach, we are going to continue to have this problem.

I remember, maybe it was Dr. Geller that said, you know, one of the problems with mental illness is that often people don't recognize that they have a problem, and if people don't recognize that they have a problem, you can build as many beds as you want, people are not going to get there unless they are forced into those beds. The solution is to have resources in the community where people can—for example, in Philadelphia, we have mobile crisis teams that can go out and reach out to people before they are hospitalized. Those kinds of services I think are critical.

Mr. TONKO. Thank you. And so as you build that infrastructure and that holistic response, Dr. Evans, what is the appropriate way to measure the amount of inpatient beds that would be required in a given community?

Mr. EVANS. I think that that is a very difficult question to answer, and people have used things like population and so forth. The reality is that it depends on how your service system is structured. If you have a service system that has resources on the front end, for example, in Philadelphia, we have a network of five crisis response centers, so we don't have the problem of people going to emergency departments who are in psychiatric crisis, not to the ex-

tent that you have in other cities. We have a mobile crisis team that can do outreach, and so in Philadelphia that might look different than another system that might be similarly resourced in terms of the amount of money but doesn't have those kinds of services.

I think the issue is, we have to build a very strong community-based system that prevents people from going into crisis and we have to have the services so that when people come out of those beds, that we are able to help them in their process of recovery, we are able to help them to stabilize and we are able to do things like helping people get supported employment or to use supported employment, for example, which dramatically decreases hospitalization. So those kinds of community-based services are really important in terms of the capacity that you need.

Mr. TONKO. Thank you. And Dr. Geller, in your testimony you rely heavily on the fact that State investments in mental health have been predicated upon where they can shift most of the cost to the Federal Government. In your opinion, how could we address the Medicaid IMD exclusion without leading to a disinvestment by our States' mental health services?

Dr. GELLER. That is an excellent question. In my testimony, I mentioned that the Federal Government should offer the IMD exclusion waivers to States, requiring a maintenance of effort. The American Psychiatric Association has a position statement that is rather specific on this—I could certainly provide it to you—that indicates that a State who took such a waiver would be required to continue its expenditure as averaged over the past 5 years from all sources that they spent previously. That is not just the department of mental health but the department of children's services, department of corrections and so on and so forth. If there was a requirement for maintenance of effort, there couldn't be a reverse shift.

Mr. TONKO. Thank you. I agree with that maintenance of effort, so thank you very much, and again, to the entire panel, your testimony is very much appreciated.

Mr. MURPHY. I now recognize the gentleman from Virginia, Mr. Griffith, for 5 minutes.

Mr. GRIFFITH. Thank you, Mr. Chairman.

First, Dr. Geller, if you could provide that information to me as well that you were just talking about?

Dr. GELLER. Yes, sir.

Mr. GRIFFITH. It is very interesting. I found your testimony and everybody's testimony very informative.

Mr. Chairman, I appreciate you having these hearings. I have to say that I don't understand mental illness. It worries me because I don't, and it is one of those areas where I least like these hearings that the chairman has called because normally I have a pretty good idea of where I think we ought to go when it comes to these mental health issues. I have to confess that I am learning something every time we even have a hearing, but I am also concerned that I don't think that we have all the answers or that we even have any idea what all the answers are, so I appreciate you all helping us try to figure that out. As representatives of the people, it is interesting because we are all trying, I think, Democrats and

Republicans on this subcommittee, to figure out what we can do to make the situation better.

I don't, however, believe that in the short term we are going to be able to make huge differences because we are going to have to do some trial and error. We are going to have to try to do some new things and some different things, and I appreciate that.

In that regard, I guess I will look to Mr. Dart and to Judge Leifman. How can we make the court system better? We are not going to overnight say OK, none of the folks with mental illnesses are going to come into the court systems, but what can we do to make the court system better? You have heard from Ms. DeGette, who has a public defender background, and Judge, now Congressman Butterfield. I was a criminal defense attorney for 27 years, and I have to commend one of my judges back home. He hasn't set up a mental health court but has a mental health docket where she deals with folks who have those issues and tries to identify those in advance so that they can have the experts present to help on that.

But what types of things can we do to encourage the States and the federal system to do a better job? Until we fix it, what can we do to help out in the court systems?

Sheriff DART. Thank you, Congressman. I will be quick, because Judge Leifman and I have talked before about these things.

Getting the courts more engaged is imperative. In our court system, they have been completely disengaged. Whenever you ask them about solutions, they say well, we have a mental health court so it is done. Their mental health court usually handles about 150 cases total a year. I usually have about 3,500 mentally ill in my jail in a day. So we can't be diverted when people have programs that are inherently good but aren't getting at the heart of the problem.

What we have been doing internally is trying to identify people literally as they are dropped off from being arrested the night before, downloading quickly their information on their mental illness, and then we put a file together for the public defender. I am a former State's attorney. We put a file together for the public defender to plead with the judge that this person is not necessarily a criminal, put them in an alternative setting such as a nursing home setting. We have been doing that at my jail where I put electronic bracelets on their legs, I monitor them at this setting. The results are fantastic, as you can imagine, compared to what the other treatment would be, which is, I put them in a four by eight cell with a complete stranger with their own issues as well.

So we have been doing that, and then on the back end, we have been pretty much winging it, and that is why, Congressman, when you talk about trial and error, that really is the route that we have been going. It can't get any worse than it is now so let us try some new things. So on the back end what we have been doing is, we ourselves are putting together case plans for them. We drive them to locations where we potentially can get housing for them so they can be there and be stabilized, and then we run a 24-hour hotline when they are in crisis to get out to them to help them. But it is just what you said, Congressman. We are at a trial-and-error stage

right now but there are things such as that that certain judicial circuits could be doing. Others are better. Ours is a real struggle.

Mr. GRIFFITH. Judge?

Judge LEIFMAN. Thank you for your question. We have created an organization called the Judges Leadership Initiative with a parallel organization called the Psychiatric Leadership Group, and we are working with the American Psychiatric Foundation, and what we are doing now is, we have about 400 judges involved in this operation and we are going around the country. We have developed a curriculum to teach judges how to identify people in court who may have a serious mental illness, how to deescalate a situation in court so they don't make it worse, but more importantly, how to work in the community to set up the kind of supports you need to be able to divert this population, and so what we recommend are a couple things. A pre-arrest-type diversion where you work with law enforcement to teach them a program called crisis intervention team policing where the police are actually taught how to deescalate, where to transport and how to avoid an arrest. Our statistics are phenomenal. As I mentioned, we have closed a jail as a result of our CIT officers in Dade County. We have also taught them to set up post-arrest diversion programs so that you take low-level offenses that don't need to be in jail or felonies that are nonviolent and you make sure that they get access to treatment.

Sheriff Dart is correct. The mental health court only handles a fraction of the cases, and the data is such that unless they are taking the right people, they actually can do more harm than good, so you have to be very careful and you have to be educated.

Mr. GRIFFITH. And Mr. Chairman, I know I am out of time but could we give Chief Biasotti—I know I mispronounced that. I apologize. But could we give the chief a moment to comment on that as well?

Mr. MURPHY. Yes.

Chief BIASOTTI. I would say our main concern law enforcement-wise is the seriously mentally ill group that is unaware of their illness. I mean, that is wherein the problem lies for us. The police departments, your county directors know who these certain groups of people are because we deal with them every day, and there are answers that we can deal with that.

In a case that we had not long ago, we had a woman severely mentally ill, went into a house, no one was home, took the pit bull and put it in a closet, went upstairs, took all the clothing out of the woman's closet, put her dishes from upstairs downstairs, moved all the pictures, spent the day. The woman came home—the homeowner—and walked in on her and of course, you know, had a cow right then and there, called the police. The police come, and she was totally out of her mind, psychotic, carrying on. So when I arrived at the police station on a different matter, I heard this screaming coming from our booking area. She was in the booking area, you know, voices were talking to her and she was complaining she was being raped by whatever at the time while she is sitting there. So I made a decision at that point, which a lot of people don't do, but being familiar with this topic I said listen, we are not arresting her for burglary. I said she is going to go to the psych unit but I am going to send a letter with her saying that she

is obviously dangerous. She could have been killed. Whoever came home could have shot and killed her is most likely to happen. I said if we arrest her, she is going to go to the county jail, she is going to be a major problem for them. From there our officers are going to go out to grand jury where they are going to move to indict her for whatever. She will be in jail for a year before they decide that she is so mentally ill that she can't stand trial, and then she will be back here again. I said so let us get her into the system now and put her through that service. But I accompanied that with a letter to our county mental health director saying I strongly suggest that, you know, she is proven to be dangerous, she has a long history, to herself, mostly; I suggest that you enter her into the assisted outpatient treatment program. This program, they provide the services to her through this program. She has not been a problem since. They monitor her, make sure that she is in some kind of treatment, and as long as she is in treatment, she is not a problem. However, if we went the legal system as we normally would do, we would be dealing with her every few weeks because she has anosognosia, she does not believe she is ill.

And I know, you know, stigmatism is a big concern, and my wife and I both pray for the day that our daughter has the insight that Mr. Rahim has into her illness because I believe if she had that insight, she could seek what everybody is talking about, care in the community. It has been 20 years almost and she does not have that insight. She has voices, and they are, as she is concerned, a supreme being.

Mr. GRIFFITH. I hate to cut you off but my time is way over.

Chief BIASOTTI. I am sorry.

Mr. GRIFFITH. That is all right. No, I appreciate the testimony. Thank you, Mr. Chairman, and I yield back.

Mr. MURPHY. That was valuable because New York, as I understand, has actually reduced their incarceration rates and homeless rates, I think by 70 percent. It has been a massive savings.

Chief BIASOTTI. That is correct, through AOT.

Mr. MURPHY. Thank you. Ms. Schakowsky, you are recognized for 5 minutes.

Ms. SCHAKOWSKY. Well, I am so glad I got here because I wanted to say a special welcome to my great friend, Sheriff Tom Dart. We were seatmates for a while in the Illinois General Assembly. And I wanted to really talk to you about a problem I know you are struggling with so much.

The New York Times article "Inside a Mental Hospital Called Jail" really focused on the largest mental health center in America. It is a huge compound here in Chicago with thousands of people suffering from mania, psychosis, other disorders, all surrounded by high fences and barbwire. That is the county jail.

So I wish you would just briefly discuss how cuts to mental health programs and services have affected individuals with mental illness that are now in your custody.

Sheriff DART. Thank you so much, Congresswoman, and it is great seeing you again.

You know, you almost don't know where to start because up until about 5 years ago, the normal process in our jail 5, 6 years ago and, frankly, from my understanding, in most jails around the

country now, when you get that court order to release somebody, you release them. The court is ordering their release and you have got to let them go, so you let them go. What we were seeing is out in front of our jail, there were people that just wandered around, stayed there, and as I had mentioned earlier, we have people trying to break back in. One threw a planter through a window to crawl back into the jail, and then we had to arrest him.

The reality of it is, is that when we were releasing people, they had nowhere to go, and in the face of that, in our State we have made tremendous cuts, I mean, just over the last 10 years. We are one of the leading States in cutting mental health funding, period, and in the city of Chicago, we just cut in half our clinics in the community. So when the people leave, not only do they have nowhere to go, there was no plan whatsoever, and as I had referenced earlier, I do think this is doable with not great expenditures because we literally have everything about this person in our possession. So if you are trying to think of case plans and diagnosing them and what would be the best strategies, there is a myriad of things we can do, but when you have no place for them to go—I used to hand out a resource book in my first couple of years as sheriff to give people a place to go. I had to stop doing that because everything in it was wrong because most of the things that we were trying to steer people toward were all closing, and so we were then setting them up to fail because there was nothing really out there.

And so the cuts are so tremendous, it has left all the locals including ourselves trying to devise unique, creative strategies on what to do including, as I say, I will drive people now. If I can find homes for them, we will drive them there. I mean, I will contact their family members ahead of time to get them to come pick people up, and mind you, we are happy to do this, but I don't think in anyone's estimation sheriffs should be doing this. We are supposed to lock people up, and that is really sort of supposed to be the end of it, but there is nothing else out there, and in our county in particular, it has really been bad, and it is desperate, and it is really heartbreaking. I talk with the detainees frequently, and do we have bad people in the jail who have committed offenses who have mental illness? Yes, we have those. The vast majority of them, though, are good people who are suffering from mental illness and the reason they are there is because of the mental illness. It is not because they are a criminal, and yet we treat them like criminals, they are housed with criminals, and then when we leave them, we basically pat them on the back and say good luck and we will see you soon, and then we are all puzzled that they are back with me.

Ms. SCHAKOWSKY. So it is not just a matter then of driving them to a place. It is that at the end of the day there is no place for many of them, right?

Sheriff DART. There is no place for them, and there is no one to work with them because they need a certain level of case managing to make sure they stay on their meds, that when they do go into crisis they are not left to doing what is going on right now, which they call myself and my staff and we try to figure out what we can help them with. There are things that we can do that will not be

expensive that can help and it be a continuum of care. It could work with people. It won't be 100 percent successful but it can't conceivably be any worse than what we do now.

Ms. SCHAKOWSKY. And what are those simple things?

Sheriff DART. Oh, upon leaving the jail, if I had someone from a county agency, State agency that would literally be their case manager who would just literally work with them through housing issues, staying on their meds so that they don't start self-medicating which is, you know, no surprise that we are having this heroin epidemic in our county because it is the next best thing to their meds is the heroin and so cheap these days. They stay on their meds. Housing—there is some housing available. It is not the best but it is not that expensive. I was paying for housing out of my own budget but I have run out of money now. So as Judge Leifman said, if we had a continuum working with the medical side but also with the judiciary, we could have something that could be somewhat of a model for a lot of people and not that expensive.

Ms. SCHAKOWSKY. Thank you very much, and thanks for what you are doing.

Sheriff DART. Thank you so much. It is great seeing you.

Mr. MURPHY. I just want to follow, Sheriff Dart. You heard Chief Biasotti talk about New York has assisted outpatient treatment where they make sure, as long as that person has been shown to be a safety risk or they have had an episode of violence or jail time before, they can work with a judge and they work on an agreement to stay on their medication and get in treatment. Now, I understand you don't have that in Cook County. Am I correct?

Sheriff DART. No. We had some intervention just literally days ago from our State Supreme Court to try to rearrange and help our local judiciary in doing their job, but we have not had engagement from our judiciary. I will be honest with you: you need an enlightened judiciary who clearly understands the distinction between criminal law and mental illness and know that there are other paths to go. Because otherwise you are left with, frankly, Mr. Chairman, isolated judges who get it, who will run certain courts and frankly take risks. We for years now, as I say, have been putting all these files together to hand to the public defender to just show the mental health background here, the lack of criminality, and yet they go up and they might as well be talking in a foreign language to the judge. The judge does the same thing. They throw them in the jail and we continue to do the same work.

So an enlightened judiciary that is engaged with it, and it does happen in other jurisdictions. It would be absolutely remarkable. It would save money.

Mr. MURPHY. Thank you. Mrs. Ellmers, you are recognized for 5 minutes.

Mrs. ELLMERS. Thank you, Mr. Chairman, and again, thank you to the panel. This is one of those situations where I have questions for every one of you, but unfortunately, we don't have enough time for that, so I will try to stay focused to the point of how we can as legislators help this issue and try to focus on those areas where we think there is the greatest need, at least to get it started, because Mr. Dart, as you have pointed out, we are in a pretty bad place right now so anything we do is going to improve the situa-

tion, and I am very concerned about those who are being released from jail and, you know, not able to continue their treatment, because as you have pointed out, it is just cyclic, and Mr. Biasotti as well.

Ms. Ashley, I do want to go back to one of the issues that has been raised, and I know we are discussing medical coverage. I know some of my colleagues are saying if we just had a bigger Medicaid system, that that might actually help the situation. You know, obviously you know we are dealing with that every day here, trying to make our health care coverage system work better. If I remember correctly from your testimony and previous questions, you said you have private insurance that your son was able to receive treatment under. Is that correct?

Ms. ASHLEY. Yes, it is. I have him as a disabled adult under my insurance.

Mrs. ELLMERS. OK. So you actually have insurance coverage but still had the difficulties. It wasn't just an issue of here is my insurance card, therefore I am going to get mental health services for my son?

Ms. ASHLEY. Right. In fact, he is denied some services in the community because he does have private insurance.

Mrs. ELLMERS. I see. OK.

Ms. ASHLEY. Even though he has SSI and Medi-Cal, they have no way to bill the insurance to get it denied and then go on Medi-Cal, so I don't even have access to a lot of the support services that are available in my community because he is on private insurance, and people have even told me to take him off private insurance, and really, having private insurance is what gets him hospitalized quickly because the lights go off when they see that I have private insurance versus Medi-Cal or Medicaid.

Mrs. ELLMERS. I see. Now, to that point, one of the things that I was wondering, when you were describing your situation in the emergency room, and I have seen this in so many hospitals where they literally brought me to the designated area in the emergency room that they have literally put together because of this situation so that they can give the best treatment possible but they are still hampered because they are obviously not a psychiatric unit, and they are dealing with the situation. Was he able to at least start receiving mental health treatment while he was there in the emergency room? I mean, was that pretty much at a standstill until he received the psychiatric bed?

Ms. ASHLEY. Right. He was put in four-point restraints and heavily sedated until they transferred him to the hospital.

Mrs. ELLMERS. OK. And you did mention that, so I thank you for that. And again, that is an area we are trying to fix. You know, there are so many pieces and parts to this issue.

Mr. Biasotti, one of the things that I would like to clarify even just for committee is the difference between civil commitment and forensic commitment, if you can answer that question, because I think that will help us as well because I think sometimes we do find ourselves again struggling with the situation of those who do not acknowledge that they have a problem and yet they are having a psychotic episode.

Chief BIASOTTI. And that is where the problem lies. The police will bring the person from their home or from wherever the instance occurs to the emergency room, usually against their will, under a State code for imminent dangerousness and then they are relying on the interview at the hospital for the psychiatrist to make a determination that they meet the standards to hold for a 72-hour period for evaluation for commitment under that standard. So I think Dr. Geller could probably help me with the difference between the civil—I am more familiar with how we would do it.

Mrs. ELLMERS. Dr. Geller, would you like to expand on that then?

Dr. GELLER. Sure. Every State has its mental health act, and that allows people to be civilly committed, usually on a standard of dangerous to self, dangerous to others or gravely in need of care, and there is no crime involved. Forensic commitment would mean that a person has been charged and booked and then they are going to be committed usually initially for a determination of competency to stand trial, criminal responsibility, or both, that you heard about earlier. If they cannot stand trial or are found not guilty by reason of insanity, then they can be further committed under a criminal statute of that State.

Mrs. ELLMERS. And yes, Dr. Hirshon?

Dr. HIRSHON. I think it may vary state by state but in my state, what happens is, there is a fixed number of inpatient beds, and these individuals who are on forensic, not the ones who have been convicted but they are often the pretrial folks will be taking up the beds that I will be looking for from the emergency department. So it doubly impacts it because it then backs up my system because the forensic folks are being housed in that situation.

Chief BIASOTTI. And if I could add, from a law enforcement aspect, most of the people that we are talking about we are bringing in not because of crimes, we are bringing them in just because of bizarre activity or dangerousness. The criminal aspect, we would have to make an arrest and it would go through the jail system and they would arrange for psychiatric evaluation.

Mrs. ELLMERS. And Judge Leifman, I think you look like you wanted to indicate, and I realize I have gone over my time but I would love to hear from you.

Judge LEIFMAN. What is happening is, the forensic beds are actually taking over the civil beds, because it is constitutional, because if you are arrested on a felony generally and you are incompetent to stand trial, you have to go—

Mrs. ELLMERS. To a—

Judge LEIFMAN. —for competency restoration. So as the States don't want to expand those budgets, they just start to use the civil beds for forensic beds. So it is really creating this horrible pressure.

Mrs. ELLMERS. I see. Well, thank you all, and Mr. Rahim too and Ms. Ashley for your personal stories. It is so important for us to hear because we need to understand how we can deal with this situation better, and again, thank you to all of you. This has been a very, very good subcommittee hearing, and I am hoping that we will really be able to fix this problem. Thank you.

Mr. MURPHY. Thank you, Mrs. Ellmers. I now recognize Mr. Harper for 5 minutes.

Mr. HARPER. Thank you, Mr. Chairman, and I thank each of you for being here and helping us, and we hope in the process we will be able to look at some suggestions and directions and things that may help you.

Chief Biasotti, if I could ask you, you know, you have described obviously law enforcement being the front line on counteracting the impacts of serious mental illness in the community. What kind of burden is this on your resources and your department?

Chief BIASOTTI. Well, that is the problem. That is what my paper focused on, and it was that most police agencies are very small in this country. The big cities are the anomalies. So for instance, in my department, which is considered midsized with an authorized staff of 50 officers, we will have three or four cars per shift, a minimum of three on the road per shift. So normally when we deal with a severely mentally ill person who is acting violent, it requires at least two of our officers. So that is two out of three people available. Now we have one officer for a municipality, a good-sized municipality, until those officers are free. A lot of times the ambulance can't take them because they are too combative and the hospital wants you to stay with them while they are in the emergency room until they make a determination as they are staying, which is because if they decide they are not staying, they don't want this psychotic person in their lobby and you need to take them back to where you came from. So it is a great depletion of resources for law enforcement nationwide, especially those in the rural areas.

Mr. HARPER. You know, I actually was a city prosecutor for about 6 years before I came here, and that was always the thing, and I appreciate what you said you do because sometimes you know they don't need to be incarcerated; they need to get help. Because not every department does it that way. So I want to commend you for that.

Chief BIASOTTI. Well, it is difficult because you also have a crime victim that doesn't understand why the person that broke into their house is not going to jail, so you have to have cooperation on a lot of levels. But also to that end, what I wanted to bring up quickly is, I got to work with Governor Cuomo's office on the SAFE Act, the back end, Kendra's Law, and one thing that I think we are hopeful is going to make a change is, one of the changes in Kendra's Law mandates that in prison settings, those who are receiving psychiatric care in the prison will be evaluated upon release for inclusion into an assisted outpatient treatment program, which hadn't happened before. Before that, your time is up and you're out the door and there goes your treatment. So we are hoping that that is going to make changes and lessen recidivism.

Mr. HARPER. Thank you very much.

Dr. Evans, I was looking at your title as we were going here, and I am also seeing what Ms. Ashley has gone through on a personal level, and what you have too, Chief. I have a 24-year-old son with fragile X syndrome, so he has intellectual disabilities. So how do you distinguish between, you know, classic mental illnesses or someone with an intellectual disability that someone who is not trained may not recognize? Give us some wisdom or advice. What do you—how do you handle that?

Mr. EVANS. Sure. So the easy way to make the distinction is that if a person has an intellectual disability, that is pretty much permanent. So those kinds of disabilities are lifelong, and our goal there is not necessarily recovery but it is really to help people have a high quality of life, to have self-determination. Mental illnesses are treatable, and one can have a very severe mental illness, schizophrenia, for example, bipolar illness, and can recover and can do well. It doesn't happen all the time but the majority of the time and so that is really the distinction. We work with people differently based on that.

Mr. HARPER. You know, with my son, if he were out by himself, if he was maybe in a sensory overload moment, it might be misinterpreted as to what he has, so training and understanding and realizing that every case, every person is different I know is an important thing for you.

Mr. EVANS. It is, and I think that educating the community about mental illnesses and intellectual disabilities is a real important part of this because you have heard the impact that stigma has on people reaching out for help, on the shame that comes with that, and I think that our strategies have to not only include how do we change the service system but like we have done with other illnesses like cancer. You know, 30, 40 years ago, people used to whisper that and now people have marches about that and walks about that, and I think it has changed how people reach out for help when they need it. It has changed how we funded research and treatment. And I think the same thing applies to mental illness and behavioral health conditions.

Mr. HARPER. Thank you, Dr. Evans, and thanks to each of you. Mr. Chairman, I yield back.

Mr. MURPHY. Thank you. Dr. Burgess asked, we have two items here from the New York Times and from Freedom magazine regarding some cases from 1992 and 1993 that he would like to have submitted into the record, so without objection.

[The information appears at the conclusion of the hearing.]

Mr. MURPHY. And Ms. DeGette, you have a clarifying question?

Ms. DEGETTE. I just have a clarifying comment, Mr. Chairman, and I just want to say again, I have been on this subcommittee for 18 years, and this is, I think, maybe the best panel we have ever had, so thank you all for coming. You have practical solutions. You had different takes on the mental health system, and I hope that each of you will be willing to make yourselves a resource to the chairman and myself as we move forward in our efforts.

Chief, you referred to Kendra's Law, and I just wanted to put in the record what that is, so you can correct me if I am wrong. I understand what this is. It is a law that was passed in New York that establishes more structured treatment combined with resources across the mental health system, and it is designed to get treatment to folks earlier on without having them participate in the penal system like Sheriff Dart was talking about or in the emergency room system. It is designed to get them treatment. But of course, you have to have an investment to do that of resources.

The chairman and I were up here talking about this, and if you did have this investment of resources and you were really able to implement things like this, it would actually probably save money

because you wouldn't be putting these people in incarceration or in very expensive ER situations. Every single person here is nodding their head. I would like to just say that for the record.

Thank you very much.

Chief BIASOTTI. If I can say, the shame of it is, we have 45 States that have a very similar law but very few use it.

Ms. DEGETTE. Because they are probably not putting the resources into it, right?

Chief BIASOTTI. That is correct.

Ms. DEGETTE. Thank you. And we are going to try to work to see what the federal partnership that we can have with all 50 States to help this along.

Thank you, Mr. Chairman.

Mr. MURPHY. Thank you. And Chief, along those lines, I understand, for example, California has a law on the books but only Nevada County, only one county, uses it.

Chief BIASOTTI. In California, it is optional by county, and only one county, correct.

Mr. MURPHY. Let me say this. Deep thanks—oh, Dr. Burgess wants a brief comment.

Mr. BURGESS. Just as a brief follow-up. Dr. Evans, in your testimony you talk about the introduction of peer specialists. This has come up before in briefings that we have had. This strikes me as likely one of the most cost-effective ways to get rational treatment decisions and to keep people in their treatment. So I do hope you will share with the committee your experience with that. We are constrained under budgetary rules. We can never score a savings from something that will actually save money. It always scores as a cost. But perhaps this is one of those areas where spending the money wisely would in fact be a good investment. I thank you for bringing that to our committee today.

Mr. EVANS. Could I just—

Mr. BURGESS. Sure.

Mr. MURPHY. Real quick.

Mr. EVANS. I think that there are data that support that peer services are cost-effective. I think it is probably the most important thing that we have done in our service that not only gives people hope but one of the real challenges is keeping people engaged in treatment, and we have found nothing that is more effective than a person who has gone through the experience, connecting with another individual, and keeping that person connected, giving that person hope, frankly. It makes a huge difference, and we have one program where we have instituted peers. We have reduced our crisis visits by a third, and half of those visits would have resulted in an inpatient stay. So we have saved millions of dollars, we believe, by implementing peer services.

Mr. BURGESS. Thank you. I yield back.

Mr. MURPHY. Mr. Rahim, you wanted to comment on that?

Mr. RAHIM. Again, thank you so much for giving patients voice, and I think a couple of words. I know Mr. Dart talked about enlightenment, but I think enlightenment means compassion, dignity and education. So I think each of us has an ability to be compassionate and we have ability to treat each patient as an individual and with dignity, and I think through contact with people who are

doing well and then that follow-up education as a foundation and groundwork, we can do so much good. So I do thank you again.

Mr. MURPHY. And again, my thanks to the whole panel. Just a couple of suggestions. While you are in town, I hope you stop in at your Member of Congress and say it is important to do some mental health reforms.

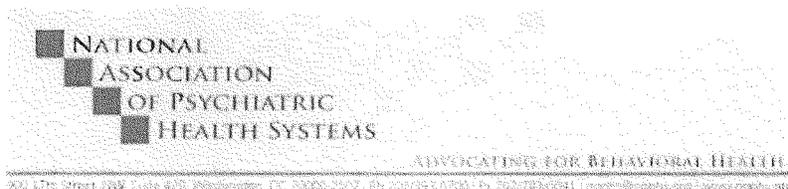
I am committed to do this and I know Representative DeGette is too. It has been since 1963, as you referenced, Dr. Geller, the last time this country really did some major mental health reforms. It is long overdue. I know you are all passionate about this but I hope you energize your own Members of Congress as well to help them understand the importance of moving forward on this.

Even though you spoke for 5 minutes and you added a few minutes to other things, oftentimes people go through life and wonder if their voice makes a difference, it does. Yours does, and it will continue to echo throughout the House of Representatives and this Nation. So I thank you a great deal for all that. And Mr. Rahim, you used the word "hope." Where there is no help, there is no hope, and we will make sure we continue to work on that help.

So in conclusion, again, thank you to all the witnesses and members that participated in today's hearing. I remind members they have 10 business days to submit questions for the record, and I ask that all witnesses agree to respond promptly to the questions. Thanks so much. God bless.

[Whereupon, at 12:25 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]



March 26, 2014

The Honorable Tim Murphy
U.S. House of Representatives
Washington, DC 20515

Dear Rep. Murphy,

On behalf of more than 700 hospitals and mental health and addiction treatment organizations who serve people of all ages, we are writing to thank you for holding today's hearing titled "Where Have All the Patients Gone? Examining the Psychiatric Bed Shortage." We would respectfully request that this letter be submitted as part of today's hearing record.

We also applaud your introduction of the *Families in Mental Health Crisis Act* (H.R. 3717), which will address many of the longstanding treatment barriers that people face all too often when they seek mental health and addiction treatment services.

Two key questions your hearing today is addressing are:

- Why are psychiatric patients often boarded in emergency departments? and
- What short-term and long-term options are available to mitigate the harmful impacts of psychiatric boarding?

For far too long, the Medicaid law, which provides the single largest funding source for those living with mental illnesses, has discriminated against people with these disorders. The Medicaid Institution for Mental Diseases (IMD) exclusion prevents adult Medicaid enrollees (ages 21 to 64) from accessing short-term, acute care in psychiatric hospitals. The IMD exclusion is penalizing the disabled and poor. And people are not getting the psychiatric hospital treatment they need, putting families and communities at risk.

Inpatient beds in the U.S. have dropped from more than 550,000 beds in 1955 to 40,000 today. Between 1990 and 2000, inpatient psychiatric beds per capita declined by 44% in state and county mental hospitals, 43% in non-governmental psychiatric hospitals, and 32% in general hospital psychiatric units. This major decline in psychiatric beds has resulted in people with mental and addictive disorders being housed in emergency departments (EDs) for days or weeks, waiting for psychiatric treatment. When EDs are backlogged, everyone suffers as people with other critical illnesses have to wait longer for treatment.

According to the Centers for Medicare and Medicaid Services (CMS), "due to the IMD exclusion, many Medicaid enrollees with acute psychiatric needs, such as expressing suicidal or homicidal thoughts, are diverted to general hospital emergency departments, which often lack the resources or expertise to care for these patients. For the Medicaid beneficiary, this may result first in a delay in treatment, and then when treatment is provided, inadequate care. General hospitals may delay the provision of care until a bed becomes available, or inappropriately assign them to medical beds."

Today, inpatient psychiatric care is delivered in the community in short-term, acute care settings, including freestanding psychiatric hospitals. Inpatient psychiatric care is an integral component of community-based care for people living with mental illnesses, and it makes no sense from a public-policy

-continued-

Page 2 – NAPHS

or from a patient-centered perspective to limit the inpatient psychiatric hospital settings that people in need of this life-saving service can access. And that is exactly what the IMD exclusion does.

Just as for medical problems, people living with mental illnesses rely on their doctors and hospitals for ongoing care and treatment. When they need life-saving treatment, they want to go to the hospital and doctors that have been treating them over time. Restricting access to psychiatric hospitals through the IMD exclusion means that patients may not be able to go to hospitals that their doctor recommends or where their doctor has inpatient practicing privileges.

There is broad support for eliminating the IMD exclusion. In responses to a Senate Finance Committee open letter to the mental health community requesting input on how to improve the U.S. mental health system, 242 stakeholders responded. A February 2014 summary noted that "many letters argued that the IMD exclusion has the overly broad effect of preventing Medicaid patients from receiving otherwise quality residential or psychiatric hospital care. In fact, it was asserted that the exclusion prevents a category of care (specialty psychiatric residential or hospital care) that could be critical to some patients in need. A common recommendation was to eliminate this exclusion," the summary said.

In the end, this is – pure and simple – a fairness issue. A Medicaid insurance card covers hospital treatment for all other conditions, but adults with mental illnesses cannot use their Medicaid insurance card for inpatient care in a psychiatric hospital. No other disorder limits their choice of hospitals in the way the IMD exclusion does.

Modifying the IMD exclusion is not just the right thing to do; in the end, it will result in more timely access to life-saving inpatient treatment, reduce emergency backlogs, and make the system more cost-effective.

Clearly, modifying the IMD exclusion would expand access to timely inpatient psychiatric care and at the same time reduce unnecessary time spent in the emergency department. Yet, there are many other reasons why people end up in emergency departments, including not being able to access outpatient community services. Early intervention and support services can help people better manage their mental illness, thereby reducing the need to seek emergency psychiatric care. It is paramount that a full continuum of services is available so that people living with mental illnesses can receive the right care at the right time, thereby improving outcomes and saving money.

Thank you, again, for holding this hearing and introducing the *Families in Mental Health Crisis Act*. We look forward to working with you and all members of Congress and the Administration to make the mental health and addiction care delivery system more responsive to the needs of people living with these disorders.

Sincerely,



Mark Covall
President and CEO

The New York Times

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July 31, 1992

8 Big Insurers Sue National Medical Enterprises

By PETER KERR

Eight leading insurance companies filed suit yesterday in Federal court charging National Medical Enterprises, one of the nation's largest operators of psychiatric hospitals, with a "massive" scheme to commit insurance fraud by admitting thousands of patients who did not need hospitalization and treating them at inflated prices.

The insurers, including Prudential and Travelers, contend that National Medical Enterprises systematically manipulated the diagnoses of patients to keep them in hospitals until their health insurance coverage was exhausted. The insurers, lawyers say, will seek hundreds of millions of dollars in damages.

The suit, filed in Washington, echoed allegations made against National Medical Enterprises in Congressional hearings last April and in State Senate hearings in Texas last year. But the suit represents the first action against the company by the nation's leading insurers and the first public charges that National Medical systematically committed insurance fraud in most of the 22 states in which it operates.

A lawyer for the insurance companies, Thomas Brunner, said the suit marked a substantial initiative on the part of the giant insurers to crack down on fraud as a way to help bring spiraling health-care costs under control.

"This suit clearly signals that these insurers intend to take an active role in ferreting out and halting insurance fraud," Mr. Brunner said. "Fraud is a significant factor in the upward pressure on health-care costs."

But in a written statement, National Medical said that the insurance companies were trying to avoid facing what it said was the real issue: a failure to pay for medically necessary psychiatric care. On July 20, National Medical filed its own suit against three of the insurers -- Massachusetts Mutual, Mutual of Omaha and Travelers -- saying they failed to pay claims.

"It is clearly a response, which we expected, to our earlier suit seeking \$45 million for their failure to pay for care," the statement said.

Between 1988 and 1991, the insurers' suit charges, National Medical and its psychiatric hospital division, Psychiatric Institutes of America, received more than \$490 million from the eight insurers. Although Mr. Brunner said he would not estimate how much of that money was obtained fraudulently, he said it amounted to hundreds of millions of dollars and that his clients were seeking triple damages.

Based on sworn testimony and documents obtained from National Medical, Mr. Brunner said, the insurers will be able to prove that the management ordered hospitals to disregard the medical needs of patients and admit them to tap their insurance benefits. The suit contends that the patients, including those who did not need hospitalization, were not released until their insurance coverage ran out.

A Defense Department study of private psychiatric hospital cases, released in April, found that in 64 percent of the cases, patients -- mostly relatives of military personnel -- should never have been admitted, were kept longer than necessary or had medical histories for which the hospitals could not justify treatment. National Medical has acknowledged that its staff in its Texas hospitals engaged in practices that appalled the company's management at its Santa Monica, Calif., headquarters. But the company has steadfastly denied that it committed insurance fraud or that problems existed in the other 21 states where it operates.

The other companies involved in the suit are Northwestern National Life, United of Omaha Life, Time Insurance, and Phoenix Home Life.

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Psychiatry's \$40,000,000,000 Fraud

In August 1993, the largest case of health care fraud in U.S. history began to unravel.

Investigations

by five agencies – the Federal Bureau of Investigation, the Internal Revenue Service, the U.S. Postal Service, the Defense Criminal Investigative Service and Health and Human Services' Investigations Division – culminated in raids by hundreds of federal agents on facilities of National Medical Enterprises in 14 states. NME ultimately paid a record total of several hundred million dollars in fines and quit the psychiatric hospital business altogether.

Investigators discovered fraud to be endemic within the psychiatric industry – so pervasive that today it constitutes a top law enforcement priority of the U.S. Department of Justice.

There is even more to tell.

By Mark Stout

Forty billion dollars.



That's enough to hire 1.1 million new teachers, orbit 100 space shuttles, or fund *all* veterans benefits and services for a year.

And that's a close estimate of the amount institutional psychiatry shamelessly rips off from the government or from insurance companies *each year*. Dollar for dollar, it is the most corrupt part of the health care system.

Expect psychiatry to come under further scrutiny in April 1997, when the Illinois Public Mental Health System and state psychiatric institutions go to trial in a class-action suit filed four years ago.

The 17-page complaint lodged by three former patients on behalf of all individuals admitted to Illinois state hospitals charged that each of the state's psychiatric institutions "houses patients in a dangerous, violent and filthy environment." It alleges chronic mismanagement, waste and inefficiency on the part of the state institutions. Industry sources expect the Illinois case to have as profound an impact on public mental health systems throughout the nation as did the revelations of fraud at National Medical Enterprises three years ago.

Insiders say that Illinois will be on the defensive from the outset. A report by federal court-appointed experts has already substantiated the plaintiffs' claims.

The experts, appointed in 1993 with the consent of all parties, documented deficiencies in almost every aspect of the Illinois mental health system. Investigators concluded that 40 to 80 percent of patients are subjected to treatment environments that are overly restrictive and expensive. The report charged that the most vulnerable patients are abandoned, that restraints and seclusion are excessively used and that people are denied privacy, respect and dignity – conditions symptomatic of "the neglect that characterizes the care provided patients in Illinois state psychiatric hospitals."

Lawsuits such as the one in Illinois have been brought against the psychiatric industry and its institutions for decades. But psychiatry continues to sing the same old song. First, psychiatrists create barbaric conditions with funds they coax from the public coffers. Then, when their excesses and their abuses are exposed, they blame it on insufficient funds and demand more.

Now, though, people know the tune, and it's time the music stops.

Just as fraud in the private psychiatric sector cost billions and taught a valuable lesson, so now the lesson is being extended to state psychiatric systems. The Illinois case may extend into a nationwide investigation surpassing the national probes earlier this decade.

Ironically, National Medical Enterprises' Psychiatric Hospitals Division was once referred to as the "Mr. Clean" of the psychiatric industry. Thus, it comes as no surprise that psychiatric institutions owned by Charter Medical Corporation, Community Psychiatric Centers and Hospital Corporation of America were also found guilty of fraud and patient abuse following the NME scandal.

The proof of fraud and abuse lies in the actions of practitioners.

Author Joe Sharkey explored problems in psychiatric institutions in his 1994 book, *Bedlam: Greed, Profiteering and Fraud in a Mental Health System Gone Crazy*, pointing out that the sweeping justice actions brought against the private hospitals did not change psychiatry's modus operandi:

"As anyone who watches television and reads the papers is aware, psychiatric hospitals, psychiatric wings of general hospitals, and addiction treatment centers are still eagerly trolling for customers who have insurance.

"And the profession of psychiatry, which was allowed through the news media to shrug off the hospital scandal and blame it almost exclusively on hospital operators, continues making bold strides into the general medical field, with its plans to become a standard component of much hospital treatment.

Meanwhile, the news media avidly continue to promote the claims by psychiatrists and psychologists that we are a nation suffering from an epidemic of mental illness that requires professional treatment."

"Fraud in Psychiatry Is Alive and Well"

In September 1993, the U.S. General Accounting Office cautioned that because of "increased scrutiny by insurance companies" and other factors, Medicaid and other government funding sources would become the primary targets of psychiatric fraud.

That warning came too late. Psychiatrists and psychiatric institutions had already bilked Medicaid by means of a new scheme. Their target: Medicaid's Early and Periodic Screening, Diagnosis and Treatment Comprehensive Care Program.

Designed to pay for early detection and treatment of medical and dental problems, Medicaid had expanded this program to provide mental health coverage in April 1992.

Hundreds of children – including 205 boys and girls between the ages of one and five in Texas alone – suddenly became "mentally ill" and were placed in psychiatric institutions at a cost of \$800 a day. Payments to private psychiatric institutions in Texas soared from \$342,291 in April 1992 to \$2,332,127 in August 1992. After Medicaid clamped down on the bogus admissions and new state laws went into effect in September 1993, the amount dropped to a trickle: \$1,467 per month.

A number of the psychiatric hospitals involved recently paid settlements to Texas after defrauding the Crime Victims Compensation Fund – established to aid victims of crime. A similar situation was also reported in Oklahoma.

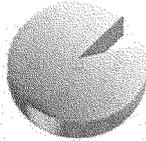
The July/August 1995 issue of the *John Cooke Fraud Report*, an industry publication of fraud investigators, noted that anyone who believed psychiatry would never dare to hospitalize people who were not sick to begin with in order to milk their insurance dry was "dead wrong."

The report stated, "Fraud in psychiatry is alive and well and apparent in the delivery of every area of mental health and substance abuse treatment around the country."

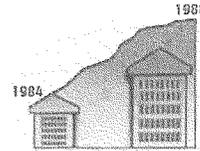
Many new examples of psychiatric fraud have proven the statement to be only too true. One instance involved a psychiatrist who bilked another psychiatrist's insurance company to treat the "Post Traumatic Stress Disorder" his colleague supposedly acquired after a minor fender-bender.

In another case, a Georgia psychiatrist, James E. McClendon, reduced his Medicaid billings for treatment of children and adolescents from \$6.6 million in 1994 to \$6.1 million in 1995. Those billings caught the attention of the Georgia Department of Medical Assistance (DMA), which investigated and found he had billed out an average of 488 hours of therapy a week.

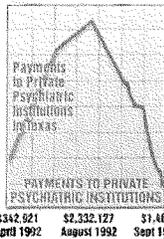
Fraud: Alive and well in the psychiatric industry



of the \$411 Million paid in Health-care related fines in 1994 \$375 Million Were paid by psychiatric Hospitals.



In one four-year period, the number of psychiatric institutions doubled.



OUTBREAK OF "MENTAL ILLNESS": After medical coverage expired in April 1992, many children suddenly became "mentally ill" and wound up in psychiatric institutions. After measures went into effect in 1993 to clamp down on fraud, the mysterious "outbreak" disappeared.

The DMA soon learned McClendon wasn't alone. Several other mental health practitioners billed Medicaid in the neighborhood of \$1 million a year

– likely the reason expenditures for one mental health program increased more than 11-fold in four years. Many Georgia children were actually recruited through door-to-door solicitation and flyers. That Fuller-Brush approach to psychiatric sales is not only atrocious. It's also illegal.

Not only did this procedure subject children to dangerous psychiatric drugs and other treatments they did not need, it denied vital services to others. Medicaid funds were not available for such items as vision care and preventive dentistry.

Meanwhile, Aetna Life Insurance Company learned it had been victimized by psychiatric fraud on the other coast. Near the end of 1995, Aetna filed a multimillion-dollar lawsuit against psychiatric institutions owned by Paracelsus Healthcare Corp.

The suit stated that psychiatric hospitals in Southern California lured unsuspecting patients from throughout the country with false promises and improper perks. Once there, they received false diagnoses and were detained until their insurance coverage ran out. Aetna said it and other insurers lost millions in the plot to "put heads in the beds."

"Business as Usual"

After Charter Medical Corporation settled with the Texas Attorney General's Office following the industry-wide fraud scandal in 1993, it said it would use the settlement as an opportunity to "reassert our leadership in industry reform and our commitment to higher standards for patient care and treatment." But it led the industry in the wrong direction. In December 1995, Charter paid the Texas Attorney General's Office another \$1.5 million for violating the settlement agreement.

"It's business as usual. Hasn't changed one bit," Dr. Walter Afield, M.D., president of Mental Health Programs Corporation, a company that monitors mental health claims for more than 36 leading insurance companies, said. "If you've got lots of good insurance, you're going to wind up in the hospital."

Psychiatrists seem to go out of their way to prove Afield is right. On February 12, 1996, the *Orlando Sentinel* reported that unsuspecting overweight people were being lured by advertisements for luxurious fat farms into psychiatric hospitals which then billed Medicaid for insurance to "treat" their "mental illness." Florida Medicare fraud complaints soared from 10,000 in 1992 to 25,000 in 1994.

As this article goes to press, a new scandal is brewing in Colorado. While other health care providers were forced to endure Medicaid cuts, psychiatric facilities for youth were allowed to continue billing at higher rates. Seeing the availability of funds, greedy psychiatric centers signed up children and adolescents faster than the state could raise the money.



As reported on July 10, 1996, in *The Denver Post*, "The centers in turn have become victims of their

own success; once they saw that more state money was available, more residential centers signed up with Medicaid ... [and] the state responded to the higher caseloads by dropping the per-case rates."

The *Denver Business Journal* offered a clue as to why psychiatric centers – glutted with staff – claimed they could not endure the cuts imposed on the rest of the health care industry. The *Journal* reported that the state-run Colorado Mental Health Institute at Fort Logan had 15 psychiatrists and 15 psychologists on staff but only 24 beds. Charter Centennial Peaks Behavioral Health System maintained 97 psychologists and 22 psychiatrists to care for patients in 72 beds. One "frugal" hospital of 57 beds limits its psychiatric staff to 50.

"If you've got lots of good insurance, you're going to wind up in the hospital."

– Walter Afield,
M.D.
President Mental Health
Programs Corporation



Psychiatry's \$40,000,000,000 Fraud continued...

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April 11, 2014

Dr. Jeffrey L. Geller, M.D., M.P.H.
Professor of Psychiatry
University of Massachusetts Medical School
73 Twinbrooke Drive
Holden, MA 10520

Dear Dr. Geller:

Thank you for appearing before the Subcommittee on Oversight and Investigations on Wednesday, March 26, 2014, to testify at the hearing entitled "Where Have All the Patients Gone? Examining the Psychiatric Bed Shortage."

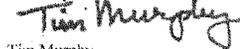
Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

Also attached are Member requests made during the hearing. The format of your responses to these requests should follow the same format as your responses to the additional questions for the record.

To facilitate the printing of the hearing record, please respond to these questions and requests with a transmittal letter by the close of business on Friday, April 25, 2014. Your responses should be mailed to Brittany Havens, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to brittany.havens@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,



Tim Murphy
Chairman
Subcommittee on Oversight and Investigations

cc: Diana DeGette, Ranking Member, Subcommittee on Oversight and Investigations

Attachments

Jeffrey Geller, MD, MPH
Professor of Psychiatry at the University of Massachusetts
Medical Director of the Worcester Recovery Center and Hospital
Staff Psychiatrist at the Carson Community Mental Health Center

Attachment 1 – Additional Questions for the Record

The Honorable Tim Murphy

1. As you have had time to reflect on your hearing testimony, do you have anything you wish to clarify or to elaborate relating to your testimony or in response to issues discussed at the hearing?

CLINIAL GUIDELINES FOR THE USE OF AOT (Assisted Outpatient Treatment)

1. The person must express an interest in living in the community.
2. The person must have previously failed to live safely in the community.
3. The person must have that degree of competency necessary to understand his/her AOT order.
4. The person must have the capacity to comply with the AOT order.
5. The treatments within the AOT order must have demonstrated efficacy when used by others like the person.
6. The AOT-ordered treatments must be such that they can be delivered by the outpatient mental health system, are sufficient for the person's needs, and are deemed necessary to sustain the person in the community.
7. The AOT-ordered treatments must be such that they can be monitored by staff in the outpatient mental health system.
8. The outpatient mental health system must be willing to deliver and enforce the AOT-ordered treatments.
9. The public sector inpatient system must support community agencies in their provision of AOT-ordered treatments.
10. The AOT order must be such that risk is mitigated if the person is complying with his/her AOT-ordered treatments.

Adapted from Geller Jeffrey L: Clinical guidelines for the use of involuntary outpatient treatment. Hospital and Community Psychiatry 41:749-755, 1990.

Attachment 2 – Member Requests for the Record

The Honorable Paul Tonko

2. Please provide the Committee with the American Psychiatric Association position statement that you referenced during the hearing.

Position Statement on Federal Exemption from the IMD Exclusion

Approved by the Board of Trustees, July 2007

Approved by the Assembly, November 2005

"Policy documents are approved by the APA Assembly and Board of Trustees... These are... position statements that define APA official policy on specific subjects..." – *APA Operations Manual*.

States should be offered the opportunity to receive a Federal exemption from the IMD Exclusion for State Hospitals and all Nonprofits over 16 beds, e.g., private hospitals, community residential programs, dual diagnosis residential treatment. To participate in the exemption a state must demonstrate a maintenance of effort (maintain its mental illness and substance abuse expenditures (excluding medication costs) from all sources, e.g., state's DMH, DPH, DMA, DMR, DOC, DSS, DYS, other) at a level no less than the state's average expenditure over the preceding five years.

http://www.psychiatry.org/File%20Library/Advocacy%20and%20Newsroom/Position%20Statements/ps2007_IMDexclusion.pdf

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CHAIRMAN

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Madison (202) 225-2922
Metcalf (202) 225-3841

April 11, 2014

Dr. Jon M. Hirshon, M.D., M.P.H.
American College of Emergency Physicians
2121 K Street, N.W.
Suite 325
Washington, D.C. 20037

Dear Dr. Hirshon:

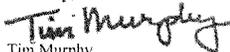
Thank you for appearing before the Subcommittee on Oversight and Investigations on Wednesday, March 26, 2014, to testify at the hearing entitled "Where Have All the Patients Gone? Examining the Psychiatric Bed Shortage."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions with a transmittal letter by the close of business on Friday, April 25, 2014. Your responses should be mailed to Brittany Havens, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to brittany.havens@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

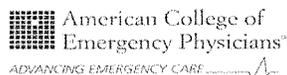
Sincerely,



Tim Murphy
Chairman
Subcommittee on Oversight and Investigations

cc: Diana DeGette, Ranking Member, Subcommittee on Oversight and Investigations

Attachment



April 23, 2014

The Honorable Tim Murphy
 Chairman
 House Committee on Energy and Commerce
 Subcommittee on Oversight and Investigations
 2125 Rayburn House Office Building
 Washington, D.C. 20515

Dear Chairman Murphy:

This is the response from Jon Mark Hirshon, MD, MPH, PhD, FACEP, FAAEM, FACPM, to your April 11, 2014 questions following the March 26, 2014 hearing entitled "Where Have All the Patients Gone? Examining the Psychiatric Bed Shortage."

1. Do you know of any setting other than psychiatric hospitals where Medicaid arbitrarily prohibits federal payments for patients receiving treatment for any other health condition?

No

2. As you have had time to reflect on your hearing testimony, do you have anything you wish to clarify or to elaborate relating to your testimony or in response to issues discussed at the hearing?

America's emergency departments treat more than 130 million patients each year and more than 16 million of them are treated for a mental health or substance abuse (MHSA) condition. Once in the emergency department, psychiatric patients board three times as long as other patients while emergency physicians look for an available bed or facility that is willing to accept the patient for admission. Meanwhile, these psychiatric patients require resource intensive care, which has an impact on the quality of care for all emergency department patients.

After my participation in the psychiatric bed shortage hearing recently, I have had time to reflect on all of the testimony presented that day to the committee and it is even more evident the sheer magnitude of the mental health epidemic impacting not only our emergency departments but all facets of our communities across the nation. This national crisis impacts individuals as well as our communities. For example, in a recent conversation with an emergency physician colleague, he told me about a psychiatric patient that they had boarding in their emergency department for 42 days waiting for appropriate placement. Stories like this reinforce the impact on both individuals as well as on all emergency department patients.

Mass deinstitutionalization of mental health patients over the past few decades did not result in successful community integration of individuals needing psychiatric services because the necessary services and funding were not put in place for adequate community support. As a result, increasing numbers of chronically mentally ill individuals have no place to go for comprehensive treatment. Rather than being integrated into the community, this population has been supplanted into other facilities, such as nursing homes, jails and prisons, while a growing number routinely seek acute psychiatric care in the nation's emergency departments.

As the committee and Congress continue to grapple with this issue and look for meaningful and successful solutions, the American College of Emergency Physicians (ACEP) stands ready to serve as a resource. The prevalence of mental illnesses in this country, combined with a lack of resources to care for these individuals in the most appropriate setting, is a national crisis and it is vital that Congress, state and local communities work together to find meaningful solutions to this problem.

FRED UPTON, MICHIGAN
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
RANKING MEMBER

ONE HUNDRED THIRTEENTH CONGRESS
Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6115
Majority (2021-2025-2927)
Minority (2071-225-3041)

April 11, 2014

Mr. Michael Biasotti
Chief of Police
New Windsor Police Department
555 Union Avenue
New Windsor, N.Y 12553

Dear Mr. Biasotti:

Thank you for appearing before the Subcommittee on Oversight and Investigations on Wednesday, March 26, 2014, to testify at the hearing entitled "Where Have All the Patients Gone? Examining the Psychiatric Bed Shortage."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

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Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,


Tim Murphy
Chairman
Subcommittee on Oversight and Investigations

cc: Diana DeGette, Ranking Member, Subcommittee on Oversight and Investigations

Attachment



MICHAEL C. BIASOTTI
Chief of Police

TOWN OF NEW WINDSOR
POLICE DEPARTMENT
555 UNION AVENUE
NEW WINDSOR, NEW YORK 12553
Telephone: (845) 565-7000 • Fax: (845) 563-4694



RICHARD S. HOVEY
Deputy Chief of Police

4/17/2014
Michael Biasotti
New Windsor Police Department
555 Union Ave.
New Windsor N.Y. 12553

Honorable Tim Murphy
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, D.C. 20515-6115

Dear Congressman Murphy:

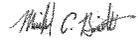
Thank you for affording me the opportunity to testify before such a prestigious committee, addressing what I consider to be one of the most important issues concerning our country today. As both a Police Chief and the father of a daughter suffering with severe mental illness, I have personally experienced two of the major issues discussed at the hearing. Issues that I believe are impediments to successful outcomes for our severely mentally ill population, their families and the criminal justice system in general. First and most importantly, HIPAA excludes families from active participation in the medical decisions of their loved one's care. Instead it assumes that a person with a severe mental illness can make competent decisions regarding their care, many cannot. It is the families that first see deration in their loved ones condition, and the families that deal with the constant consequences of their repeated states of crisis. It is also the families that deal with the resulting tragedies. (Homelessness, Arrest, Incarceration and Suicide) In cases of severe mental illness, early intervention by the family results in earlier care and far fewer crisis situations. HIPAA should be amended in cases of severe mental illness, so that the family, those who know them the best are included in treatment decisions.

Secondly the IMD exclusion must be changed, it adds to the continued reduction of psychiatric bed availability through the country. Ample psychiatric beds do not exist to properly stabilize the current number of persons in psychiatric crisis today. The result is persons being released in a matter of hours, not because they are adequately stabilized but because psychiatric bed space is not available. In many cases early return to the community when not fully stabilized, results in interaction with law enforcement and an introduction to the criminal Justice System. Ample hospital bed space would break this cycle, ensuring adequate stabilization before return to the community setting them up for success rather than failure.

I can tell you from experience, from a family perspective, that there is nothing more frustrating and

depressing than to feel that your government is working against you, as you attempt to get help for your loved one, someone who is too ill to seek help for themselves.

Sincerely,

A handwritten signature in black ink, appearing to read "Michael C. Biasotti". The signature is written in a cursive style with a horizontal line extending from the end.

Michael Biasotti
Chief of Police
New Windsor Police Department

FRED UPTON, MICHIGAN
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
RANKING MEMBER

ONE HUNDRED THIRTEENTH CONGRESS
Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6115
Majority: (702) 225-2227
Minority: (202) 225-2845

April 11, 2014

Dr. Arthur C. Evans Jr.
Commissioner
Department of Behavioral Health and Intellectual disAbility Services and
University of Pennsylvania
1101 Market Street, Suite 700
Philadelphia, PA 19107

Dear Dr. Evans:

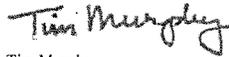
Thank you for appearing before the Subcommittee on Oversight and Investigations on Wednesday, March 26, 2014, to testify at the hearing entitled "Where Have All the Patients Gone? Examining the Psychiatric Bed Shortage."

During the hearing, Members asked you to provide additional information for the record. Those requests are attached. The format of your responses to these requests should be as follows: (1) the name of the Member whose request you are addressing, (2) the complete text of the request you are addressing in bold, and (3) your answer to that request in plain text.

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Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,



Tim Murphy
Chairman
Subcommittee on Oversight and Investigations

cc: Diana DeGette, Ranking Member, Subcommittee on Oversight and Investigations

Attachments

Arthur C. Evans, PhD Response to Honorable Dr. Burgess

April 25, 2014

Question: *Please elaborate on your experience with the introduction of peer specialists.¹*

The introduction of peer specialists in Philadelphia has been one of the most important developments in improving service delivery and outcomes for individuals with behavioral health needs. Since 2006, the city of Philadelphia Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) has supported a statewide initiative to train Certified Peer Specialists (CPS). Over 680 CPS have been trained to date, with approximately 40% of these individuals employed through this training. However, because of their effectiveness, it is now an expectation that behavioral health providers funded by DBHIDS hire at least 2 CPS, so we anticipate that the number of trained CPS employed will rapidly grow in the coming years.

CPS are employed by a wide range of behavioral health providers in Philadelphia including inpatient psychiatric facilities, community mental health centers, psychiatric crisis response centers, residential substance abuse programs, outpatient addictions programs and mobile mental health teams. With the addition of CPS, facilities and agencies have reported improved recovery outcomes for individuals with behavioral health conditions and improved employee satisfaction among professionals as they see significant clinical improvement in individuals in their programs and economic gains for the agency as they improve client retention. One agency in particular has been able to hire 25 full-time CPS solely due to increased fee-for-service revenue resulting from CPS' effectiveness in improving access and retention of individuals in the treatment program.

For the last five years, DBHIDS has also provided other instruction programs to supplement the CPS trainings for individuals with lived experience, their family members, and community members. Over 2,500 individuals have participated in these trainings. DBHIDS is also planning to provide increased support to behavioral health and non-behavioral health agencies to prepare them for

¹ Original testimony provided on March 26, 2014 at a hearing of the Subcommittee on Oversight and Investigations "Where have all the patients gone? Examining the Psychiatric Bed Shortage."
<http://energycommerce.house.gov/hearing/where-have-all-patients-gone-examining-psychiatric-bed-shortage>

effectively employing peer specialists. This is to ensure that organizations are equipped to maximize the benefit peers can bring to an agency.

We would like to thank Dr. Larry Davidson of Yale University who has collaborated with us in the development of our peer specialist initiative. He has provided some additional background information on peers and their role nationally in behavioral health systems.

Since the introduction of hiring peers (i.e., persons with histories of mental illness who have recovered or are in recovery) as staff in the early 1990s, peer support practitioners have become the fastest growing component of the mental health workforce. At present, over 30 states have made arrangements with their state Medicaid office to capture reimbursement for the services provided by peer support specialists, and most of the remaining states have developed peer-delivered services based on the use of general fund or SAMHSA block grant dollars. The Veterans Health Administration alone has hired over 1,000 peer specialists over the last several years. As a result of the rapid growth and proliferation of this new profession, a national set of practice guidelines were developed and disseminated in 2014; an ethics statement and set of practitioner competencies are currently under development (Davidson, 2014).

Peers were initially hired to provide conventional mental health services such as case management and residential and employment supports (e.g., job coaches). The first generation of studies on these forms of peer staff showed that peers were able to perform these functions equally as well as existing (non-peer) paraprofessional staff, with no differences in outcomes. The only positive difference for peer specialists was found in one study of outreach and engagement to persons who would have been eligible for mandated outpatient treatment in a state that did not yet have outpatient commitment. To be eligible, participants had to have a serious mental illness, have shown a positive response to acute care during a previous hospitalization, have a pattern of refusing outpatient services once discharged, and have a history of violence or be at risk for violence. Participants were randomly assigned to either an outreach team that had hired peer staff or an outreach team that had not hired peer staff. Those participants who were assigned to peer outreach staff became engaged in treatment more quickly and reported having a better relationship with staff than those who were assigned to non-

peer staff. In this particular study, no adverse events were reported for participants in either study condition over the two-year duration of the project (Sells, Davidson, Jewel, Falzer, & Rowe, 2006).

Once the feasibility of hiring peer staff became established, the peers themselves began to partner with mental health practitioners and researchers to develop and evaluate roles for peers that made more use of their relevant life experiences and talents. One of the reasons given to explain why peer staff initially were not showing superior outcomes over non-peer staff in conventional roles was that the roles they were trained for and hired into did not allow them to make use of the unique strengths they brought to their work. As a result, a number of more properly peer roles have been developed that enable peer staff members to offer a unique form of support (now called *peer support*) that involves them making use of their own recovery stories to instill hope in the persons they serve. They also use the lessons and wisdom they have accrued through their own resilience in the face of adversity—along with relevant training and supervision—to facilitate, guide, and mentor other people's recovery journeys through role modeling and supporting people in their own efforts to reclaim meaningful, self-determined lives in the communities of their choice.

Peers offering this kind of support have found it tremendously gratifying to be allowed to give back to their communities in such valuable and effective ways, and research has begun to show that peer support that is based on the peer staff's own recovery narratives and their role modeling of self-care does in fact produce superior outcomes on a number of important dimensions. Several of these studies also have begun to show cost savings as a result of the introduction of this form of peer support to persons who have histories of using intensive and costly forms of acute care. The roles that peers play vary across these studies offer a beginning list of the diverse ways in which peer support can be provided depending on the specific needs and preferences of specific subpopulations. What follows are examples of this diversity; this is not an exhaustive list of relevant research.

One particularly promising use of peer support has been for persons leaving inpatient care, especially when they have a history of readmissions. A 1998 study found a 72% reduction in readmissions among New York state residents who were offered a peer *bridger*, while a 2010 study found a similar reduction (73%) in hospital days in Tennessee (New York Association for

Psychiatric Rehabilitation Services, 2012)². A more recent *bridger* study found a reduction of 42% in the rate of readmissions and a 48% reduction of days spent in the hospital (Sledge, et al., 2011). A 2013 review commissioned by the National Health Service in England of these and other studies, entitled “Peer support in mental health care: Is it good value for the money?” calculated that, on average, every British pound (£) spent on *peer bridger* services results in the savings of £4.75 due to reductions in hospital use (Trachtenberg et al., 2013). This model is now being extended to help *bridge* the gap between prison and the community for persons with mental illnesses who are being discharged from prisons.

Another strategy for reducing hospital days is that of developing peer-run crisis respite programs that can serve as alternatives to hospital admission (Repper & Carter, 2011; Sledge et al., 2011). A 2010 study of one such diversion program found that 90% of the 227 persons served in that year did not need to be hospitalized in the two years following their stay. The crisis respite program had a cost of \$353 per day compared to the cost of one day in the hospital of \$1,400, resulting in a projected cost savings of over \$1,000 per day for each of the 748 days participants spent in the respite program (for a total savings of \$748,000 in one year) (New York Association for Psychiatric Rehabilitation Services, 2012).

In addition to these kinds of costs savings, peer support has been shown to increase hope, empowerment, well-being, and quality of life, and reduce substance use and depression, among persons with mental illnesses with histories of multiple hospitalizations, criminal justice involvement, and/or co-occurring substance use disorders. Peer support has been used to reduce health disparities for persons with mental illnesses from racial and ethnic minority communities (e.g., people of African and/or Hispanic origin), and to increase the involvement of persons with mental illnesses in their own care. A recent study conducted within the VA system, for example, found that veterans who were randomly assigned to care teams that included peer specialists became significantly more activated for and interested in taking care of themselves (Chinman et al., 2013).³

² For more information, see <http://www.nyaprs.org/peer-services/peer-bridger/> (accessed 4/25/2014).

³ For more information, see <http://www.blogs.va.gov/VAntage/9368/help-fellow-veterans-become-a-va-peer-specialist/> and <http://www.vacareers.va.gov/peer-to-peer/index.asp> (accessed 4/25/2014).

As health care systems aim to improve the quality of services provided to the mentally ill, there will be heightened interest in building on the ability peers have to activate persons with mental illnesses and to teach them self-care skills as members of interdisciplinary health home teams. Peers are particularly well-suited to function as health navigators for exchanges in the Affordable Care Act, and several studies are currently examining the various health and mental health outcomes of peers functioning in this way as Wellness Coaches. Preliminary findings suggest that the use of peers may enhance the timely access of persons with mental illnesses to primary care and specialty medical services and improve their physical and mental health while at the same time reduce their overall Medicaid costs (Chinman, et al., 2014; Davidson, et al., 2012).

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