EXAMINING H.R. 2646, THE HELPING FAMILIES IN MENTAL HEALTH CRISIS ACT

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE

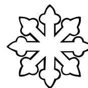
HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTEENTH CONGRESS

FIRST SESSION

JUNE 16, 2015

Serial No. 114–55



Printed for the use of the Committee on Energy and Commerce

energycommerce.house.gov

U.S. GOVERNMENT PUBLISHING OFFICE

97–621 WASHINGTON : 2016

For sale by the Superintendent of Documents, U.S. Government Publishing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2104 Mail: Stop IDCC, Washington, DC 20402–0001

COMMITTEE ON ENERGY AND COMMERCE

FRED UPTON, Michigan
Chairman

JOE BARTON, Texas
Chairman Emeritus
ED WHITFIELD, Kentucky
JOHN SHIMKUS, Illinois
JOSEPH R. PITTS, Pennsylvania
GREG WALDEN, Oregon
TIM MURPHY, Pennsylvania
MICHAEL C. BURGESS, Texas
MARSHA BLACKBURN, Tennessee
Vice Chairman
STEVE SCALISE, Louisiana
ROBERT E. LATTA, Ohio
CATHY MCMORRIS RODGERS, Washington
GREGG HARPER, Mississippi
LEONARD LANCE, New Jersey
BRETT GUTHRIE, Kentucky
PETE OLSON, Texas
DAVID B. MCKINLEY, West Virginia
MIKE POMPEO, Kansas
ADAM KINZINGER, Illinois
H. MORGAN GRIFFITH, Virginia
GUS M. BILIRAKIS, Florida
BILL JOHNSON, Ohio
BILLY LONG, Missouri
RENEE L. ELLMERS, North Carolina
LARRY BUCSHON, Indiana
BILL FLORES, Texas
SUSAN W. BROOKS, Indiana
MARKWAYNE MULLIN, Oklahoma
RICHARD HUDSON, North Carolina
CHRIS COLLINS, New York
KEVIN CRAMER, North Dakota

FRANK PALLONE, JR., New Jersey
Ranking Member
BOBBY L. RUSH, Illinois
ANNA G. ESHOO, California
ELIOT L. ENGEL, New York
GENE GREEN, Texas
DIANA DEGETTE, Colorado
LOIS CAPPS, California
MICHAEL F. DOYLE, Pennsylvania
JANICE D. SCHAKOWSKY, Illinois
G.K. BUTTERFIELD, North Carolina
DORIS O. MATSUI, California
KATHY CASTOR, Florida
JOHN P. SARBANES, Maryland
JERRY MCNERNEY, California
PETER WELCH, Vermont
BEN RAY LUJÁN, New Mexico
PAUL TONKO, New York
JOHN A. YARMUTH, Kentucky
YVETTE D. CLARKE, New York
DAVID LOEBSACK, Iowa
KURT SCHRADER, Oregon
JOSEPH P. KENNEDY, III, Massachusetts
TONY CÁRDENAS, California

SUBCOMMITTEE ON HEALTH

JOSEPH R. PITTS, Pennsylvania
Chairman

BRETT GUTHRIE, Kentucky
Vice Chairman
ED WHITFIELD, Kentucky
JOHN SHIMKUS, Illinois
TIM MURPHY, Pennsylvania
MICHAEL C. BURGESS, Texas
MARSHA BLACKBURN, Tennessee
CATHY MCMORRIS RODGERS, Washington
LEONARD LANCE, New Jersey
H. MORGAN GRIFFITH, Virginia
GUS M. BILIRAKIS, Florida
BILLY LONG, Missouri
RENEE L. ELLMERS, North Carolina
LARRY BUCSHON, Indiana
SUSAN W. BROOKS, Indiana
CHRIS COLLINS, New York
JOE BARTON, Texas
FRED UPTON, Michigan *(ex officio)*

GENE GREEN, Texas
Ranking Member
ELIOT L. ENGEL, New York
LOIS CAPPS, California
JANICE D. SCHAKOWSKY, Illinois
G.K. BUTTERFIELD, North Carolina
KATHY CASTOR, Florida
JOHN P. SARBANES, Maryland
DORIS O. MATSUI, California
BEN RAY LUJÁN, New Mexico
KURT SCHRADER, Oregon
JOSEPH P. KENNEDY, III, Massachusetts
TONY CÁRDENAS, California
FRANK PALLONE, JR., New Jersey *(ex officio)*

CONTENTS

	Page
Hon. Joseph R. Pitts, a Representative in Congress from the Commonwealth of Pennsylvania, opening statement	1
Prepared statement	2
Hon. Gene Green, a Representative in Congress from the State of Texas, opening statement	4
Hon. Fred Upton, a Representative in Congress from the State of Michigan, opening statement	6
Prepared statement	7
Hon. Frank Pallone, Jr., a Representative in Congress from the State of New Jersey, opening statement	8

WITNESSES

Creigh Deeds, Senator, Senate of Virginia	11
Prepared statement	13
Patrick J. Kennedy, Former U.S. Representative (RI), and Founder, Kennedy Forum	17
Prepared statement	19
Jeffrey A. Lieberman, M.D., Chairman, Department of Psychiatry, Columbia University College of Physicians and Surgeons	23
Prepared statement	25
Answers to submitted questions [1]	135
Paul Gionfriddo, President and CEO, Mental Health America	
Prepared statement	38
Steve Coe, Chief Executive Officer, Community Access	52
Prepared statement	54
Mary Jean Billingsley, Parent, National Disability Rights Network	66
Prepared statement	68
Harvey Rosenthal, Executive Director, New York Association of Psychiatric Rehabilitation Services	73
Prepared statement	75
Answers to submitted questions [2]	137

SUBMITTED MATERIAL

H.R. 2646 [3]	
Congressional Research Service memorandum, submitted by Ms. Schakowsky	116
GAO Mental Health report entitled, "HHS Leadership needed to Coordinate Federal Efforts Related to Serious Mental Illness," submitted by Mr. Murphy [4]	
GAO Mental Health report entitled, "Better Documentation Needed to Oversee Substance Abuse and Mental Health Services Administration Grantees," submitted by Mr. Murphy [5]	
Statement of the American Roundtable To Abolish Homelessness, submitted by Mr. Murphy	118
Statement of the American College of Emergency Physicians, submitted by Mr. Murphy	121
Statement of the National Alliance on Mental Illness, submitted by Mr. Murphy	123
Statement of the American Psychological Association, submitted by Mr. Murphy	124
Statement of the American Academy of Child & Adolescent Psychiatry, submitted by Mr. Murphy	126
S. 1299 [6]	

Page

Article entitled, "Fatal Police Shootings in 2015 Approaching 400 Nationwide," Washington Post, May 30, 2015, submitted by Messrs. Tonko and Butterfield 128

---

[1] Mr. Lieberman did not respond to submitted questions by the time of printing.

[2] Mr. Rosenthal did not respond to submitted questions by the time of printing.

[3] Available at: *http://docs.house.gov/meetings/if/if14/20150616/103615/bills-1142646ih.pdf*.

[4] Available at:*http://docs.house.gov/meetings/if/if14/20150616/103615/hhrg-114-if14-20150616-sd017.pdf*.

[5] Available at:*http://docs.house.gov/meetings/if/if14/20150616/103615/hhrg-114-if14-20150616-sd014.pdf*.

[6] Available at:*http://www.gpo.gov/fdsys/pkg/BILLS-114s1299is/pdf/BILLS-114s1299is.pdf*.

EXAMINING H.R. 2646, THE HELPING FAMILIES IN MENTAL HEALTH CRISIS ACT

TUESDAY, JUNE 16, 2015

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

The subcommittee met, pursuant to call, at 10:07 a.m., in room 2123 of the Rayburn House Office Building, Hon. Joseph R. Pitts (chairman of the subcommittee) presiding.

Members present: Representatives Pitts, Guthrie, Shimkus, Murphy, Burgess, Blackburn, Lance, Griffith, Bilirakis, Long, Ellmers, Bucshon, Brooks, Collins, Upton (ex officio), Green, Engel, Capps, Schakowsky, Butterfield, Castor, Sarbanes, Matsui, Schrader, Kennedy, Cardenas, and Pallone (ex officio).

Also present: Representatives Tonko and Loebsack.

Staff present: Clay Alspach, Chief Counsel, Health; Gary Andres, Staff Director; Leighton Brown, Press Assistant; Karen Christian, General Counsel; Noelle Clemente, Press Secretary; Andy Duberstein, Deputy Press Secretary; Katie Novaria, Professional Staff Member, Health; Tim Pataki, Professional Staff Member; Graham Pittman, Legislative Clerk; Chris Santini, Policy Coordinator, Oversight and Investigations; Adrianna Simonelli, Legislative Associate, Health; Sam Spector, Counsel, Oversight; Traci Vitek, Detailee, Health; Dylan Vorbach, Staff Assistant; Greg Watson, Staff Assistant; Christine Brennan, Democratic Press Secretary; Jeff Carroll, Democratic Staff Director; Waverly Gordon, Democratic Professional Staff Member; Tiffany Guarascio, Democratic Deputy Staff Director and Chief Health Advisor; Una Lee, Democratic Chief Oversight Counsel; and Samantha Satchell, Democratic Policy Analyst.

OPENING STATEMENT OF HON. JOSEPH R. PITTS, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. PITTS. The subcommittee will come to order. The chairman will recognize himself for an opening statement.

Today's Health subcommittee hearing will examine the legislation authored by our colleague, Representative Tim Murphy, H.R. 2646, which is designed to help families struggling with crisis caused by mental health disorders. The bill makes available much-needed psychiatric, psychological, and supportive services for individuals with mental illness and families in crisis.

With more than 11 million Americans who suffer with severe mental illness, such as schizophrenia, bipolar disorder, and major depression, many are going without treatment and often families struggle to find appropriate care for their loved ones. Since there is a patchwork of different programs and sometimes ineffective policies across numerous agencies, it is important for this committee to examine ways to fix the broken mental health system by focusing and coordinating programs and resources on psychiatric care for patients and families most in need of services.

Over the past several years, Dr. Murphy, a practicing psychologist, has worked diligently to discern the most effective ways to research and treat these illnesses. As chairman of the Subcommittee on Oversight and Investigations, Chairman Murphy launched a review of the country's mental health system beginning in January of 2013. The investigation, which included public forums, hearings with expert witnesses, document and budget reviews, and GAO studies, revealed that the Federal Government's approach to mental health is a chaotic patchwork of antiquated programs and ineffective policies spread across numerous agencies with little to no coordination. The Helping Families in Mental Health Crisis Act of 2015, H.R. 2646, aims to fix the Nation's broken mental health systems by refocusing programs, reforming grants, and removing barriers to care.

I am pleased we are holding this hearing to hear from our witnesses and colleagues about their views on this pending legislation. And I look forward to the testimony from each of you today.

[The prepared statement of Mr. Pitts follows:]

PREPARED STATEMENT OF HON. JOSEPH R. PITTS

The Subcommittee will come to order.

The Chairman will recognize himself for an opening statement.

Today's Health Subcommittee hearing will examine the legislation authored by our colleague, Rep. Tim Murphy, H.R. 2646, which is designed to help families struggling with crisis caused by mental health disorders. The bill makes available much needed psychiatric, psychological, and supportive services for individuals with mental illness and families in crisis.

With more than 11 million Americans who suffer with severe mental illness such as schizophrenia, bipolar disorder, and major depression, many are going without treatment and often families struggle to find appropriate care for their loved ones.

Since there is a patchwork of different programs and sometimes ineffective policies across numerous agencies, it is important for this committee to examine ways to fix the broken mental health system by focusing and coordinating programs and resources on psychiatric care for patients and families most in need of services.

Over the past several years, Dr. Murphy, a practicing psychologist, has worked diligently to discern the most effective ways to research and treat these illnesses. As Chairman of the Subcommittee on Oversight and Investigations, Chairman Murphy launched a review of the country's mental health system beginning in January 2013. The investigation, which included public forums, hearings with expert witnesses, document and budget reviews, and GAO studies revealed that the federal government's approach to mental health is a chaotic patchwork of antiquated programs and ineffective policies spread across numerous agencies with little to no coordination. The Helping Families in Mental Health Crisis Act of 2015, H.R. 2646, aims to fix the nation's broken mental health system by refocusing programs, reforming grants, and removing barriers to care.

I am pleased we are holding this hearing today to hear from our witnesses and colleagues about their views on this pending legislation.

I look forward to the testimony today and yield the balance of my time to Dr. Murphy.

[H.R. 2646 is available at: http://docs.house.gov/meetings/if/if14/20150616/103615/bills-1142646ih.pdf.]

Mr. PITTS. And I yield the balance of my time to Dr. Murphy from Pennsylvania.

Mr. MURPHY. Thank you, Mr. Chairman. Thank you for holding this hearing.

Our mental health system is broken. Badly broken. It is getting worse, and it has to be fixed. Same goes for our handling of substance abuse in this country. Forty thousand suicide deaths in this country last year, 42,000 drug overdose deaths, 60 million with a diagnosable mental illness, 10 million with serious mental illness, like schizophrenia, bipolar, severe depression, 100,000 new cases a year.

The General Accounting Office reviewed this for the committee, said we spend in the Federal Government $130 billion a year, over some 112 programs and agencies that don't work together, have little accountability, and in many cases, don't have very good results.

I ask every member of the committee during this hearing, and as we work forward on this bill, to stop and think. Imagine you have a child who is hallucinating, schizophrenic, out on the streets, and you are told that the law says you have no right to know anything about your child's location, condition, or care. Others presume that having any information is harmful to your own child. Or if your child is brought before a judge with concerns for the symptoms and the inability to care for themselves, and the judge says it is not against the law to be crazy. I ask you to stop and think about that. Are we so lacking in compassion, and are we so ignorant of what serious mental illness is? Would we say it is not illegal to have a heart attack, and walk away from a person with chest pains? Or how about dealing with someone with Alzheimer's, would we say it is not illegal to have Alzheimer's, and wonder the streets in winter, barefoot?

Look, here is the truth. Serious mental illness is a brain disorder, and we must come to terms with this critically important fact or else nothing else we do or say today will make any sense to anyone. Let me say this again. Mental illness, especially serious mental illness, is a brain disorder, and as such, has to be seen and treated for what it is. To believe otherwise is folly, anti-science, and an injustice to the person, denies them appropriate treatment, and sentence them to more imprisonment, homelessness, victimization, unemployment, and barriers to care.

So I urge members to embrace this bill, and I thank all those members on both sides of the aisle who have worked with us, and the many agencies and organizations who have done this as well. This bill is comprehensive, it is a big first step, but it does not fix everything. I wish there was a way we could go even further to build even more comprehensive changes, especially in dealing with substance abuse disorders, but this bill makes substantive changes in that so those issues will be addressed. It sets the stage for more reform.

I look forward to hearing from the witnesses, but I especially want to thank our witnesses today, and Senator Creigh Deeds, and others for coming out to tell your courageous stories. I thank Chairman Upton for helping us schedule this hearing and move this for-

ward. Let's make sure we provide more help for folks, so we understand where there is help, there is hope.

I yield back.

Mr. PITTS. The chair thanks the gentleman.

I am now pleased to recognize the ranking member of the subcommittee, Mr. Green of Texas, for his opening statement. Also to help welcome one of our former colleagues here.

OPENING STATEMENT OF HON. GENE GREEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. GREEN. Thank you, Mr. Chairman, for holding this hearing on mental health reform.

I would like to recognize our former colleague, Patrick Kennedy. Good to see you, and thank you for your service and, of course, your family. And we keep it in the family. We have a relative on the committee.

The Affordable Care Act made important changes in the field of mental and behavioral health. The law expanded access to mental and behavioral health services, advanced parity of coverage, and enabled states to expand their Medicaid programs so that millions of more Americans could access affordable quality coverage. While the ACA made great strides toward improving access to mental and behavioral health services, the mental health system is still in need of reform.

In our efforts to advance reform, it is critical that the patient remain at the center of our focus. Approximately 10 million Americans suffer from serious mental health illnesses, including major depression, schizophrenia, bipolar disorder, post-traumatic stress syndrome. The National Alliance on Mental Illness reports that between 70 and 90 percent of individuals have significant reduction of symptoms and improved quality of life with appropriate treatment and support. The numbers show that treatment works. Even though the overwhelming majority of individuals with mental and substance use disorders improved after receiving treatment, almost ½ of all adults living with serious mental illness do not receive treatment in the past year. Given that the statistics show that treatment is effective, and that a considerable number of adults still go without treatment, our efforts to improve the mental health care system must empower patients and their caregivers with access to a range of treatment and support services. We must also remove barriers to that access.

In today's hearing, we are considering several pieces of legislation that seek to reform and improve our mental health care system. They are H.R. 2646, the Helping Families in Mental Crisis Act, and H.R. 2690, the Including Families and Mental Health Recovery Act.

I appreciate my colleague from Pennsylvania, Dr. Murphy's, endeavor to advance comprehensive mental health reform, and I particularly appreciate his relationship when we have been working on this for a few years, including during the Affordable Care Act. I do have some concerns about the legislation, that it may not adequately take into account the diversity and complexity of mental health needs that patients and their caregivers present. Comprehensive mental health reform must feature community-centered

options that focus on recovery and prevention. We must ensure that reforms are patient-centered and address the full continuum of care.

I look forward to hearing today more about this legislative proposal, and I also appreciate my colleague from California, Congresswoman Matsui, for her efforts to improve mental health care delivery and the Including Families in Mental Health Recovery Act. The legislation seeks to improve the understanding of providers, patients, and caregivers on how HIPAA requirements apply to the mental health space. It will clarify HIPAA privacy standards for the release of protected information to patients' families and caregivers, and increase education on this critical issue.

I would also like to thank our witnesses here today and look forward to their perspectives.

With that, I would like to yield 1 minute to my colleague, Congressman Kennedy, from Massachusetts.

Mr. KENNEDY OF MASSACHUSETTS. I thank the ranking member, and I thank the committee for holding this important hearing. To all of the witnesses, thank you very, very much for your testimony, and look forward to your insight.

There is a familiar face, as I think everybody recognizes. Patrick, it is wonderful to see you here. I think you will probably hear from your colleagues, it is like you have never left. And that is true because it actually really is true. I get at least once a day people come up to me and say, Patrick, it is great to see you again. I get introduced often on the House Floor as the gentleman from Rhode Island. I get often many of your colleagues relate to me how grateful they are for my leadership on these issues, as they thank me, Patrick, for all that I have done. Which, of course, you can imagine I say, you are very welcome, and take all of the credit for myself. And every now and again, I let you know that, but often I don't.

But, Patrick, it is largely to your efforts in Congress that mental health parity is much closer to becoming a reality today than it was a decade ago, and that the Affordable Care Act has allowed 16.4 million previously uninsured people get the coverage that they need. But I think everyone here would agree that we still have a lot more word to do.

A lack of access to care has had a heartbreaking consequence across our country. Just recently, I saw a report that stated over ½ of youth battling severe mental illness receive absolutely no help at all. Allowing so many children to fall through the gaps in our system leads to substance abuse and addiction, crime, and violence. In Massachusetts, as you know, we are in the midst of an opioid abuse epidemic that cost over 1,000 lives last year alone. Lives of the rich and poor, young and old, male and female, black and white. Taunton, a city in my district, we have already tragically seen 10 people die just this year. It has been 7 years since the Paul Wellstone Act was signed into law by President Bush, and another year since those final rules went into effect. Lives cut short in every corner of our country serve as a stark reminder that true parity cannot wait another day.

I look forward to hearing from each of our witnesses today about how the bills we are considering and other legislation can help ensure that loved ones battling mental illness and addiction not only

have the access to care that they need, but that they can get those services without additional barriers.

Patrick, thank you.

Mr. GREEN. Mr. Chairman, whatever time I have left, which is nothing, I would like to yield to my colleague from New York, Congressman Tonko.

Mr. KENNEDY OF MASSACHUSETTS. Sorry.

Mr. PITTS. Recognized for 30 seconds.

Mr. TONKO. I thank Representative Green and the chair for the opportunity.

I am pleased we are holding this hearing on such an important topic, and I wanted to take a moment at the outset to acknowledge and welcome my constituent and my friend, Mr. Harvey Rosenthal, to the panel. Harvey and I have known each other for many years, and have long worked together to better the lives of individuals dealing with mental health challenges; most notably, with the passage of Timothy's Law, which brought mental health parity to New York State before even our federal parity protections, which are outstanding. As the executive director of the New York Association for Psychiatric Rehabilitation Services, Harvey's passion and advocacy for individuals struggling with mental illness for over 40 years is unparalleled.

So welcome, Harvey. Welcome panelists. I greatly look forward to hearing your testimony today. And with that, I yield back the balance of my time.

Mr. PITTS. The chair thanks the gentleman.

I now recognize the chairman of the full committee, Mr. Upton, 5 minutes for an opening statement.

OPENING STATEMENT OF HON. FRED UPTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. UPTON. Thank you, Mr. Chairman.

There is no question that mental illness affects millions of Americans and their families, yet sadly way too many are going without treatment and their families are certainly struggling to find care for loved ones. Following the tragic events of Newtown, Connecticut, this committee led a multiyear review of the federal mental health system. Ensuring treatments and resources are available and effectively used for those suffering with mental illnesses has remained the real priority of this committee throughout the past number of years.

I particularly commend Oversight and Investigations Subcommittee Chair Tim Murphy who has led and spearheaded our thorough review of all federal mental health programs. This committee held a series of public forums, briefings, and investigative hearings to determine how federal dollars are being prioritized and spent on research and treatment, particularly for serious mental illness. To address the flaws discovered in the extensive and wide-ranging examination, Chairman Murphy introduced H.R. 3717, the Helping Families in Mental Health Crisis Act of 2013. And two major pieces of that bill became law in the last Congress, and today we continue our efforts and look upon building on that success.

Dr. Murphy has reintroduced his bill in this Congress, building upon the previous bipartisan version while updating it to include

new findings from the committee's continuing investigation. H.R. 2646, this year's bill, would remove federal barriers to care, clarify privacy standards for families and caregivers, reform outdated federal programs, expand parity accountability, invest in services for those with serious mental illness, and promote evidence-based care. Every community, every single one, has been impacted in some fashion, and literally every family as well. To our community leaders on the frontlines, in my district, folks like Jeff Patton, who runs the Kalamazoo Community Mental Health and Substance Abuse Services, we say thank you. And to those families who have been impacted by mental illness in some form, Congress is aware, yes, we are, of your plight, and we can and we must and we will do much better.

I want to thank our witnesses for taking the time to testify before the subcommittee, particularly my friend, former colleague, Patrick Kennedy, Virginia State Senator Creigh Deeds. We have an all-star panel, that is for certain.

And I yield the balance of my time to the vice chair of the subcommittee, Mrs. Blackburn.

[The prepared statement of Mr. Upton follows:]

PREPARED STATEMENT OF HON. FRED UPTON

Mental illness affects millions of Americans and their families, yet sadly many are going without treatment and families are struggling to find care for loved ones. Following the tragic events of Newtown, Connecticut, the Energy and Commerce Committee led a multiyear review of the federal mental health system. Ensuring treatments and resources are available and effectively used for those suffering with mental illness has remained a priority of this committee throughout the past several years.

Oversight and Investigations Subcommittee Chairman Tim Murphy spearheaded our thorough review of all federal mental health programs. The committee held a series of public forums, briefings, and investigative hearings to determine how federal dollars are being prioritized and spent on research and treatment, particularly for serious mental illness. To address the flaws discovered in the extensive and wide-ranging examination, Chairman Murphy introduced H.R. 3717, the Helping Families in Mental Health Crisis Act of 2013. Two major pieces of that bill became law in the 113th Congress and today we continue our efforts and look to build upon that success.

Dr. Murphy has reintroduced his bill this Congress, building upon the previous bipartisan version while updating it to include new findings from the Committee's continuing investigation. H.R. 2646 would remove federal barriers to care, clarify privacy standards for families and caregivers, reform outdated federal programs, expand parity accountability, invest in services for those with serious mental illness, and promote evidence-based care.

Every community has been impacted in some fashion. To our community leaders on the frontlines, folks like Jeff Patton who runs the Kalamazoo Community Mental Health and Substance Abuse Services—we say thank you.

And to those families who have been impacted by mental illness in some form—Congress is aware of your plight and we can and must do better.

I'd like to thank the witnesses for taking the time to testify before the Subcommittee—in particular former Congressman Patrick Kennedy and Virginia State Senator Creigh Deeds. We have an all-star panel for sure. I yield the remainder of my time to ————————————————.

Mrs. BLACKBURN. Thank you, Mr. Chairman. And to our witnesses, we do thank you so much for being here. We are deeply appreciative of the time, and we know Congressman Kennedy has had this as an issue close to his heart for a long time, so we appreciate that you are here to share.

I think that Tim Murphy deserves a tremendous amount of credit for the work that he has put into working through this process for the past couple of years. You have 10 million Americans that are in need of services, and who suffer some form of severe mental illness. The Federal Government is spending $130 billion a year, and people are not getting the services that we need. And in our district, Centerstone is a group that we have worked with on these issues for a period of time. And we were looking at the homeless population, some of the figures related there, and the fact that so many of these individuals end up in our jails, and this is something that needs to be addressed. They are sick and they need care. And in Tennessee, there were a total of 21,246 inmates in fiscal year 2013. Of those, 11 percent were diagnosed with a severe mental illness, another 21 percent were diagnosed with nonspecific mental illness, and 16 percent were prescribed at least one psychotropic medication.

But, see, we have this gap on outcomes and what the deliverable would be. And we are so grateful to Chairman Murphy's leadership for helping us hone in on this to make certain that needs are addressed, that there is a process for care delivery, and there is a process for these individuals to have a quality of life.

And so we are going to have questions for all of you today, and we thank you for your commitment and for your time.

And, Mr. Chairman, I yield back.

Mr. PITTS. The chair thanks the gentlelady.

I now recognize the ranking member of the full committee, Mr. Pallone, 5 minutes for an opening statement.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. Thank you, Mr. Chairman. I know that Patrick Kennedy, our colleague, has gotten all kinds of accolades, but I want to add to it because, I think many of you know, or maybe you don't, that he was dealing and urging us to pass the Mental Health Parity Bill long before we even had it included in the ACA, and then he advocated when we were passing the ACA to expand it, which is exactly what happened. And I also would mention that he is not only an advocate domestically but also internationally. I remember when you and I went to Armenia together, and you went there because of the Special Olympics and trying to set up the Special Olympics in Armenia. So thanks for all that you do, Patrick, and it is good to see you.

Today's hearing gives us the opportunity to discuss an important public health issue. According to the National Alliance on Mental Illness, approximately 1 in 5 adults in the U.S., or 43.7 million, will experience mental illness in a given year. Of those people, approximately 10 million live with a serious mental illness, including major depression, schizophrenia, and bipolar disorder.

We have taken significant steps forward in recent years. The Affordable Care Act's passage was quite literally the largest expansion of mental health and substance abuse disorder coverage in a generation. The ACA prohibits individuals from being denied coverage due to a preexisting mental health condition. It expands eli-

gibility for Medicaid coverage, and requires most health plans, including Medicaid, to cover mental health and substance abuse services. Not only are services covered, but mental health parity now applies, protecting 62 million more Americans. This means that no insurer can impose requirements that are more burdensome for mental health than they can for physical health.

Despite these major advances, far too many individuals still go without the treatment they need to live long, healthy, and productive lives, and more must be done to ensure coverage translates into effective treatments, and actually meets parity standards. That is why I am interested in hearing from stakeholders on what is working, what is not working, before we move forward with extensive or comprehensive legislation. For instance, Parachute NYC is here to discuss an innovative new approach for respite care for the seriously mentally ill, and I believe we can learn valuable lessons from this project and others funded through the ACA.

Mr. Chairman, unfortunately, like last Congress, the first Health Subcommittee hearing on mental health is once again a legislative hearing on the Helping Families in Mental Health Crisis Act. As a result, the subcommittee will focus on solutions as framed by this bill, instead of being framed by the needs of individuals with mental illness and the system that serves them.

While I have concerns with this process, I want to recognize that there are provisions of H.R. 2646 that I strongly support, including the increased focus on workforce development and the parity enforcement reporting requirements. However, I am opposed to several provisions in the bill, including its changes to HIPAA that would weaken the privacy rights of individuals with diagnosed mental illness, the conditioning of community mental health block grant funding on the presence of state AOT laws or treatment standard laws, and cuts in funding to substance abuse programs to pay for new mental health programs. As we all know, too often substance abuse and mental health go hand in hand, and we have a crisis in both areas. So I hope that after this hearing we can work together and find common ground to move bipartisan legislation forward that further advances the mental health system in this country.

I would like to yield the remainder of my time to Representative Matsui.

Ms. MATSUI. Thank you, Ranking Member. And I welcome all you panelists. And nice to see you, Patrick.

All of us know that we need to reform our Nation's broken mental health system, and we should all care about this issue before, during, and after a crisis or an event that affects us personally. We shouldn't wait until a person is in an acute crisis to provide needed care and services, and we shouldn't abandon people once the immediate crisis has ended.

There is a full spectrum of mental health and illness that our system needs to address, and a full spectrum of treatment options, tools, and services and supports that we need to make available. We should not prioritize funding only for the highest level of care, such as inpatient hospital beds, at the expense of funding the rest of the continuum of care.

I believe in the power of prevention, and that we need to do more to catch many conditions, including mental illnesses, early before they progress. I know our current system is flawed, and I look forward to working with my colleagues to fix it. That is why I introduced the Including Families in Mental Health Recovery Act, which is one of the pieces of legislation that we are discussing today. Stories of patients and their families who suffer mental illness do affect me personally. Time and time again, including what will be in testimonies today, I have heard horror stories from patients, families, and providers about what happened when providers could not communicate with caregivers, and information wasn't shared. I hear from providers and families alike in the mantra; I couldn't share because of HIPAA. However, the language of the HIPAA law does not prevent information-sharing in 99 percent of the stories I hear. Rather, it is a vast misunderstanding, misinterpretation, and overly cautious application of the HIPAA law. This is important. There is a problem here, but HIPAA isn't the root cause of it, which means that changing HIPAA won't fix anything. The root problem is awareness of what is and isn't allowed under the law.

The bill that I introduced would do 2 simple things. First, formalize HHS Office for Civil Rights Guidance which clearly outlines how providers can strike the right balance between sharing information with caregivers and protecting patients' privacy. Second, it requires the development and dissemination of a model training program to educate and train providers, administrators, and lawyers, and patients and families on what can and can't be shared under the law.

I appreciate this hearing, and I look forward to working with all of you. Thank you, and I yield back.

Mr. PITTS. The chair thanks the gentlelady.

That concludes the opening statements of the members. As usual, the written opening statements from the members will be entered into the record.

We will now go to our panel, and I will introduce them in the order of their presentations.

First of all, the Honorable Creigh Deeds, Senator, Senator of Virginia. Welcome. And then our former colleague, the Honorable Patrick Kennedy, former U.S. Congressman from Rhode Island, founder of the Kennedy Forum. Jeffrey Lieberman, M.D., Chairman, Department of Psychiatry, Columbia University College of Physicians and Surgeons. Welcome. Mr. Paul Gionfriddo, President and CEO, Mental Health America. Steve Coe, Chief Executive Officer of Community Access. Ms. Mary Jean Billingsley, Parent, National Disability Rights Network. And Harvey Rosenthal, Executive Director, New York Association of Psychiatric Rehabilitation Services. Thank you all for coming today and testifying on this very, very important subject. And your written testimony will be made part of the record, and you will each be given 5 minutes to summarize your testimony.

So the chair at this point will recognize Senator Deeds 5 minutes for your summary.

STATEMENTS OF CREIGH DEEDS, SENATOR, SENATE OF VIRGINIA; PATRICK J. KENNEDY, FORMER U.S. REPRESENTATIVE (RI), AND FOUNDER, KENNEDY FORUM; JEFFREY A. LIEBERMAN, M.D., CHAIRMAN, DEPARTMENT OF PSYCHIATRY, COLUMBIA UNIVERSITY COLLEGE OF PHYSICIANS AND SURGEONS; PAUL GIONFRIDDO, PRESIDENT AND CEO, MENTAL HEALTH AMERICA; STEVE COE, CHIEF EXECUTIVE OFFICER, COMMUNITY ACCESS; MARY JEAN BILLINGSLEY, PARENT, NATIONAL DISABILITY RIGHTS NETWORK; AND HARVEY ROSENTHAL, EXECUTIVE DIRECTOR, NEW YORK ASSOCIATION OF PSYCHIATRIC REHABILITATION SERVICES

STATEMENT OF CREIGH DEEDS

Mr. DEEDS. Thank you, Mr. Chair, and thank you, members of the committee, for giving me a couple of minutes. Thank you, Congressman Murphy, for making mental health issues—to bringing them to the forefront, to helping develop solutions to help families in crisis throughout the country.

When formulating my thoughts about what I wanted to speak about today, how best to use my time, I thought about all the compelling stories that have been shared with me from Virginians and from people all throughout the United States. Honestly, I thought what could be more compelling than the loss of those innocent lives in Newtown, the moviegoers in Aurora, the bright emerging leaders of Virginia Tech, or the dedicated public servants at the Navy Yard.

In Virginia, we tinkered around the edges of public policy following the tragedy, but the real reform and meaningful work remains. But if we did not act after all those unspeakable tragedies, what could I possibly say today to you to press upon you the importance of acting, the importance of coming together and finding solutions, many of which are here before you in H.R. 2646.

In addition to each of those high-profile cases involving large losses of life, there are tragedies of smaller scales. You can read about Natasha, a woman with mental illness who ends up in jail instead of a mental health treatment facility that can properly care for someone with an illness. When the jail attempts to transfer her, six members of law enforcement in biohazard suits handcuff, shackle, and place a faceguard on her. When she refuses to bend her knees and sit in a transport chair, she is tazed multiple times. She dies. If she was in a mental health facility and needed to be sedated, the staff would have had appropriate options. I can only imagine what she was thinking and feeling when all of those men entered her cell in spacesuits, and I can only imagine how much grief and pain her family is enduring today.

You can read about Christian, a 17-year-old boy with a knife, threatening suicide. Law enforcement was called to the scene, and when the boy made movements toward the officer, he was shot dead. I can only imagine the shock and horror of his friend who had called for help.

Tragedies happen every day that involve someone in a mental health crisis. Most do not make the news. I have heard so many, and those stories serve to guide me in my review of the mental health system in Virginia. The heartbreak is unbearable. I hear

these stories, I hear them every day. People reach out to me for help every day, and the sad truth is that in many ways, there is little I can do to help. The system is not set up in a way that encourages advocacy.

One of the primary issues I see is HIPAA. We came together in a bipartisan way in Virginia to adopt meaningful reforms last year and to some extent during the 2015 Session, but nothing we do can circumvent HIPAA. I need, the states need, the Federal Government as a partner in reforming the mental health system. Government was not envisioned to work quickly, and we are geared toward incremental policy changes, but I am telling you, the time for action is now. Families are struggling. People are dying. People are grieving.

While there is no panacea, there are things to be done to improve the lives of people with mental illness, promote better outcomes, and to help give some relief to families who are struggling every day. We can accomplish this without jeopardizing the civil liberties of those with mental illness.

While I do not like to speak about my own situation, I will end briefly talking about Gus. No legislative action either here in the District of Columbia, nor in Virginia, will bring back my son, but hopefully it will help others keep their loved ones safe. I have four precious children. My three daughters make me prouder every day, but I have forever lost my son. I worked within the mental health system to help Gus when he began to show signs of mental illness. He was brilliant. Everyone in this room would envy his adeptness in picking up languages, his knowledge of religion, his ability to play any instrument he would pick up, and his kindness and gentleness to his fellow man. My world was shaken to its core when he began showing signs of delusional thinking and sporadic behavior. I was just not equipped with the knowledge or the information to help him. HIPAA prevented me from accessing the information I needed to keep him safe and help him towards recovery. Even though I was the one who cared for him, I was the one who fed him and housed him, transported him, insured him, I was not privy to any information that would clarify for me his behaviors, his treatment plan, his symptoms to be vigilant, not—I had no idea. I didn't know his diagnosis, his prescription changes, and necessary follow-up. I had sought to have him hospitalized earlier, so he was wary of my having any information. So I was in the dark as I tried to advocate for him in the best way I could with the best information I had. The last time I tried to hospitalize him, he was turned away. We ran out of time, and law enforcement had to release him.

We have to do better. Not for me, not for the countless other families who have already buried their loved ones, but for those who struggle with mental illness and the families that struggle to help them. They are crying out for help. They are desperate, they are exhausted, and they need your leadership.

Thank you.

[The prepared statement of Mr. Deeds follows:]

Examining H.R. 2646, the Helping Families in Mental Health Crisis Act
CONGRESSIONAL TESTIMONY
2322 Rayburn House Office Building
June 16, 2015, 10:00 a.m.

Thank you so much Mr. Chairman and members of the committee for allowing me a bit of time with you today. And thank you to Congressman Murphy for his efforts to bring mental health issues to the forefront and develop solutions to help families in crisis throughout the United States.

When formulating my thoughts about what I wanted to speak about today, how best to use my time, I thought about all of the very compelling stories that have been shared with me from Virginians and people from throughout the United States. Honestly, I thought what could be more compelling than the loss of those innocent lives in Newtown, the moviegoers in Aurora, the bright emerging leaders at Virginia Tech, or the dedicated public servants at Navy Yard?

In Virginia, we tinkered around the edges of public policy following tragedy, but the real reform and meaningful work remains. But if we did not act after all of those unspeakable tragedies, what could I possibly say today to press upon you the importance of acting. The importance of coming together and finding solutions, many of which are here before you in HR 2646.

In addition to each of those high profile cases involving large losses of life, there are tragedies of smaller scales.

You can read about Natasha. A woman with mental illness who ends up in jail instead of a mental health treatment facility that can properly care for someone with a mental illness.

When the jail attempts to transfer her, six members of law enforcement in biohazard suits handcuff, shackle, and place a face guard on her. When she refuses to bend her knees and sit in a transport chair, she is tazed. Multiple times. And she dies. If she was in a mental health facility and needed to be sedated, the staff would have had appropriate options.

I can only imagine what she was thinking and feeling when all of those men entered her cell in spacesuits. And I can only imagine how much grief and pain her family is enduring today.

You can read about Christian. A 17 year old boy with a knife, threatening suicide. Law enforcement was called to the scene. And when the boy made movements toward the officer, he was shot dead. I can only imagine the shock and horror of his friend that called for help.

Tragedies happen every day that involve someone in a mental health crisis. Most do not make the news. I've heard so many – and those stories serve to guide me in my review of the mental health system in Virginia. The heartbreak is unbearable. I hear these stories all of the time. People reach out to me for help every day. And the sad truth is that in many ways there is little I can do to help. The system is not set up in a way that encourages advocacy.

One of the primary issues is HIPAA. We came together in a bipartisan way in Virginia to adopt meaningful reforms last year and to some extent during the 2015 Session. But nothing we do can circumvent HIPAA. I need – the states need – the federal government as a partner in reforming the mental health system.

Government was not envisioned to work quickly. And we are geared toward incremental policy changes. But I am telling you, the time for action is now. Families are struggling. People are dying. Families are grieving.

While there is no panacea, there are things to be done to improve the lives of those with mental illness, promote better outcomes, and to help give some relief to families who are struggling every day.

We can accomplish this without jeopardizing the civil liberties of those with mental illness.

And while I do not like to speak about my own situation, I will end briefly talking about Gus. No legislative action either here in DC nor in Virginia will bring back my son. But hopefully it will help others to keep their loved ones safe.

I have four precious children. My three daughters continue to make me prouder every day. But I have forever lost my son. I worked within the mental health system to help Gus when he began showing signs of mental illness. He was brilliant; everyone in this room would envy his adeptness in picking up languages, his knowledge of religion, his ability to play any instrument he'd pick up, and his kindness and gentleness to his fellow man. My world was shaken to its core when he began showing signs of delusional thinking and sporadic behavior. I was not equipped with the knowledge or the information to help him.

HIPAA prevented me from accessing the information I needed to keep him safe and help him towards recovery. Even though I was the one who cared for him, fed him, housed him, transported him, insured him, I was not privy to any information that could clarify for me his behaviors, his treatment plan, and symptoms to be vigilant about. I did not know his diagnosis, prescription changes, and necessary follow-up. I had sought to have him

hospitalized earlier, so he was wary of my having any information. So I was in the dark as I tried to advocate for him in the best way I could with the best information I had.

The last time I tried to hospitalize him, he was turned away. We ran out of time, and law enforcement had to release him.

We have to do better. Not for me. Not for the countless other families who have already buried their loved ones. But for those who still struggle with mental illness and the families that struggle to help them. They are crying out for help. They are desperate. They are exhausted. And they need your leadership.

Thank you.

Mr. PITTS. The chair thanks the gentleman.

Patrick, you are recognized 5 minutes for your opening statement.

STATEMENT OF PATRICK J. KENNEDY

Mr. KENNEDY OF MASSACHUSETTS. Thank you, Mr. Chairman. First, I think I speak for all of us, Senator Deeds, when we say our hearts go out to you. I don't think there is a person in this country that wasn't moved by your tragedy, and what it speaks to all of us. And the notion that we have let all those tragedies go by, and as a nation, have failed to act is abominable. And I think what you have said is what we all need to hear over and over again; the time is now. And, Representative Murphy, thank you for stepping up. I know you have drawn a lot of criticism, and this bill isn't perfect, but you have had the fortitude to stick with it and to keep pressing. And you have listened to people and you have shaped legislation that moves us forward. Is it the answer, as you rightly said? No, it is just a piece of the answer. But as you said at the very start of your remarks, the essential message we need to come out of this hearing is that these are real physical illnesses, and they need to be treated with the same urgency that we would treat cancer or any other fatal or disability in this country.

The notion that we treat these issues as moral issues as opposed to medical issues is really the central issue before this committee. And I am honored to have been honored to work with many of you to get the Mental Health Parity and Addiction Equity Act passed. And that bill, if implemented, and I have heard comments already from many of you including my cousin, Joe, will transform the system because if the liability is on payers, including the Federal Government, to treat brain illnesses like any other illness, then they will start to see that an ounce of prevention is worth a pound of cure, that investing in early identification and treatment and intervention is the answer. Just like with cancer, just like with diabetes, just like with cardiovascular disease. We don't wait until these illnesses become pathologized before we treat them. But with mental illness and addiction, what do we do? We wait until you are in crisis before our system ever starts to kick in. And then people blame the system as not working because somehow it doesn't take someone with stage 4 cancer and make them well.

Are you kidding me? If we don't intervene early, these illnesses do become intractable. But we don't have to let it be that way. We can intervene early. We can save lives. But the basic premise to all this is just treat these like you would someone with cancer, and not wait around until the illness gets to become worse and in a crisis stage.

So, Representative Murphy, I am sure we will have a chance to talk in great length about the details of this bill, but I just want to salute you for putting forth a number of issues that we can talk about and we can begin to explore as ways to improve the system. The system needs accountability. The system needs transparency. And you have been a champion of those things, and I think that they are—throughout your legislation, and it is why I am honored to be here to work with you and my democratic colleagues to make

sure that this House passes something to answer what Senator Deeds put forward to us, and that is to act, and to act now.

Thank you.

[The prepared statement of Mr. Kennedy follows:]

Statement of Patrick J. Kennedy

Health Subcommittee, Energy & Commerce Committee

June 16, 2015

Mr. Chairman, Ranking Member Green, and members of the Committee, thank you for inviting me to be with you to discuss mental health legislation recently introduced this Congress.

We are here today because we aren't doing enough. I think we can all agree on that. We aren't doing enough for individuals living with mental health and substance use disorders in this country. And now that we agree on that, let's also agree that it stops today.

The state of mental health in our nation is one of great possibility. To tackle the challenges ahead of us, we must all roll up our sleeves and do our part. Federal action is key, and the individuals and families impacted by mental illness and addiction in this country cannot afford to wait any longer. I am pleased to see Republicans and Democrats in the House and Senate working diligently to seize this moment.

And in case you needed further incentive, the public is behind you and agrees that change is needed. A public opinion poll conducted by the Kennedy Forum in January of this year revealed that over 70% of Americans believe a radical or significant change is needed in the nation's approach to mental illness and addiction. This statistic not only supports Congressional action on this issue, it frankly demands it.

Congressman Murphy, I thank you for your introduction of the Helping Families in Mental Health Crisis Act of 2015 (H.R. 2646). Your dedication to improving the lives of individuals and families impacted by mental illness is inspiring. The leadership you have provided to take mental illness out of the shadows and into the light of day is not only badly needed, it goes far beyond anything we have seen in Congress in recent memory.

H.R. 2646 brings to focus some of the most important challenges facing our mental health system, including improving coordination for mental health programs and resources at the federal level, accelerating health information technology in behavioral health, taking steps to address the growing behavioral health workforce shortage, emphasizing the importance of integrating behavioral health into primary care, increasing access to psychiatric hospital beds, and supporting important research at the National Institute of Mental Health on brain disorders and self and other-directed harm.

Congresswoman Matsui, I thank you for your introduction of the Including Families in Mental Health Recovery Act of 2015 (H.R. 2690) to clarify the Health Insurance Portability and Accountability Act (HIPAA) guidance and educate providers, patients, and families about sharing information under HIPAA. I know that these issues are deeply personal to you and your family and that has shown in your steadfast commitment to increasing access to mental health services and fighting stigma.

As members of this Committee know, it is imperative that we continue to vigilantly protect patient privacy. Without the protections under HIPAA, too many patients, including those with mental illness, would choose not to seek the care they need. Congressman Murphy and Congresswoman Matsui have both put forward legislation to also make clear that HIPAA does not and should not prohibit families and caregivers from being a part of a patient's care plan and recovery. Further, the Congresswoman includes new funding that would help educate providers and families about sharing information under the law.

I know there are also ongoing efforts by your colleagues on this Committee to introduce additional and meaningful legislation to improve our behavioral health system, including Congressman Paul Tonko who will soon be introducing legislation to reform the Institutions for Mental Disease (IMDs) exclusion for the population between the ages of 22 and 64, with an aim of also addressing access for individuals with substance use disorders. I look forward to reviewing this legislation. Rethinking the IMD exclusion is critical; it is an issue of both access and equity.

I must also take this opportunity to remind members of the Committee and your colleagues that as we gather here today we have mental health laws and regulations already on the books whose

promises are going unfulfilled. I was proud to help pass the Mental Health Parity and Addiction Equity Act of 2008 during my time in Congress, but urgent work remains to be done to make equity in our behavioral health system a reality. Too many American families are being denied access to the mental health and addiction treatment they need and the toll is adding up in lives lost.

We need your leadership to ensure the law is fully implemented with strong, clear guidance from the Departments of Health and Human Services and Labor. The law also needs to be aggressively and publically enforced. We have begun to see the shortcomings of the Final Rule play out across our nation in the commercial market. Many insurance plans are failing to disclose necessary, meaningful information about their medical management practices, effectively preventing patients and providers from demonstrating a parity violation when it occurs.

As we are learning lessons in the commercial market, we must apply them to the implementation of parity in Medicaid and the Children's Health Insurance Program. In addition to lacking necessary disclosure requirements, the proposed rule (80 FR 19417) excludes long-term care services. Long term care services, inpatient and community based, are critical to the treatment and recovery of individuals with mental health and substance use disorders, particularly in the Medicaid and CHIP populations.

I support the reporting requirements proposed in H.R. 2646. I also ask for a renewed commitment by this Committee's members to apply the pressure necessary to really see this law through. It will be a marathon to be sure, but until Americans are no longer denied the care they need, we will not achieve the progress that we all are here today seeking.

Further, I know that this Committee has devoted much time and energy to investigating the opioid and heroin epidemic that is sweeping our nation with a goal of finding meaningful solutions. It is my sincere hope that the Committee will take action on this issue, from widespread access to Naloxone, to streamlining the consent process under 42 CFR part 2, to the rapid expansion of recovery treatment and services.

While I know well that addiction presents its own unique challenges, I urge this Committee to tackle mental health and addiction together. As we have seen in our history, we severely lack the political will and the collective momentum to address either of these critical issues. Too often we are presented the false choice of mental health or addiction – fund one or the other, cut one or the other. If we are to seize this moment, we must do it hand in hand. When we passed the Parity law, I made this very same case. These crises are growing, you cannot do one without the other, and no one should have to wait.

I look forward to a robust discussion of these legislative proposals and to using today to forge common ground to advance a comprehensive agenda. The change that the American people are calling for can only be found in a system that is fully integrated and driven by quality and measureable outcomes, a system that addresses behavioral health crises before they start through prevention and early intervention in our communities, places of work, and schools, and a system that above all else guarantees equity for all. Before us today is the opportunity to make this change a reality.

If we continue on the course we have been on – a grant here, a grant there – we will find ourselves repeating history. If you believe as I do that Americans can still dream big and accomplish great things, together, then we must make real investments and commitments that will transform our behavioral health system.

Again, I applaud the work being done in both chambers and on both sides of the aisle to strengthen mental health and substance use disorder care. I thank Congressman Murphy for introducing this comprehensive bill. I hope that the 114th Congress can come together to build on these ideas, renew our shared commitment to make mental health and addiction parity a reality, and reach for the real change the American people are demanding.

Mr. PITTS. The chair thanks the gentleman. Thank you for your leadership and your passion.

Dr. Lieberman, you are recognized for 5 minutes for your opening statement.

STATEMENT OF JEFFREY A. LIEBERMAN, M.D.

Dr. LIEBERMAN. Thank you, Chairman Pitts, Ranking Members Green and Pallone, and honorable committee members. I am pleased to be here attending this hearing. I also would like to thank Representatives Murphy and Johnson for their enlightened legislation, and express my gratitude to Representatives Upton and DeGette for the critical leadership on the 21st Century Cures.

I am a Professor and Chair of Psychiatry at Columbia University, and Psychiatrist-in-Chief at New York Presbyterian Hospital, and have spent my career doing research on the neurobiology and psychopharmacology of psychotic disorders. In addition, I have, throughout my career, taken care of patients, both overseeing clinics with trainees, as well as having patients directly in my own practice. I am a member of the National Academy of Sciences, Institute of Medicine, and the past President of the American Psychiatric Association. I mention this simply to say that I believe that I am in an informed perspective to express knowledgeable opinions about the field of mental illness and mental health care.

And in the course of my career, I can say that I have continuously borne witness to all that Senator Deeds and Congressman Kennedy have described to you. The stories are countless, enumerable, and appalling.

But in the time I have, I would like to make 3 points. First, that psychiatry is a scientifically based profession. No different from cardiology, neurology, or ophthalmology, although in deference to Representatives Burgess and Bucshon, maybe not as advanced as obstetrics and gynecology and cardiac surgery. But the second is that, although we have an egregious chronic crisis in mental health care, this is solvable. You deal with a lot of problems that are not solvable. Alzheimer's Disease in the aging population, global warming, terrorism. This is a solvable problem. And the third is, I want to describe what providing quality and comprehensive mental health care will do for our country.

When I was a medical student in third year in the mid-1970s at George Washington University, I told my advisor that I wanted to go into psychiatry. He exploded and said, what would you do a dumb thing like that for, and throw away a perfectly good career? Psychiatry was then, and still is, the Rodney Dangerfield of medicine. It doesn't get the respect it deserves. But that is because for the first 150 years of its existence, psychiatry had little to show for itself. No scientific information of mental illness, no effective treatments. It could do little to help people with mental illness, other than to institutionalize them, and those became appalling snake pits.

But that was then and now is now, and everything has changed since the scientific revolution of the latter 20th century, beginning with the arrival of psychotropic drugs. And as a result, psychiatry has a strong scientific foundation, and an array of evidence-based treatments that are effective and safe.

What this means is that we have the knowledge and the means to solve this crisis. To do this though, we have to provide a template of comprehensive evidence-based services to health providers at the state, county, and municipal levels, and align financing mechanisms to incentivize to providers to adopt these. In addition, and this is something that is not widely appreciated, we must dispel the stigma of mental illness, just like we have in our society for other things, such as racism, sexism, anti-Semitism. There still is prejudice against mental illness and psychiatry due to its inglorious past, but these anachronistic attitudes confuse people, create fear and mistrust of mental health care, and deter people from seeking and getting help.

The Helping Families in Mental Health Crisis Act offers a transformative opportunity. If we are successful, and we can be, we will lessen the burden of illness and improve the quality of life of our citizens. It also alleviates some of the most disturbing and dispiriting problems in our society, including domestic violence, addiction, suicide, the mentally ill who are homeless and increasingly in prisons, the shocking rates of PTSD and suicide in military personnel, and the recurrent episodes of these civilian massacres and mass violence perpetrated by some people with untreated mental illness. As a bonus, comprehensive effective mental health care would also deter the massive inflation in health care costs driven by patients with comorbid mental disorders who receive repeated and unnecessary medical and surgical services.

One final comment is that, it is imperative that in the process of revamping our mental health care system, that we be guided by scientific evidence and not ideology or opinion. Science guides cardiovascular medicine, oncology, orthopedics, neurology. It should guide mental health care as well.

The 21st Century Cures, I hope, will address an egregious chronic underfunding of the biomedical research community, because ultimately, research is what drives the quality of care. We have the means to solve this crisis. We simply need to find the social and political role.

I thank you for having me, and I await your comments and questions.

[The prepared statement of Dr. Lieberman follows:]

DR. JEFFREY A. LIEBERMAN, MD
LAWRENCE C. KOLB PROFESSOR AND CHAIRMAN, DEPARTMENT OF PSYCHIATRY, COLUMBIA UNIVERSITY COLLEGE OF PHYSICIANS AND SURGEONS; DIRECTOR, NEW YORK STATE PSYCHIATRIC INSTITUTE; AND PSYCHIATRIST-IN-CHIEF, COLUMBIA UNIVERSITY MEDICAL CENTER OF THE NEW YORK-PRESBYTERIAN HOSPITAL

TESTIMONY BEFORE THE UNITED STATES HOUSE OF REPRESENTATIVES HOUSE ENERGY & COMMERCE COMMITTEE HEALTH SUBCOMMITTEE

"EXAMINING H.R. 2646, THE HELPING FAMILIES IN MENTAL HEALTH CRISIS ACT"

JUNE 16, 2015

Chairman Upton, Subcommittee Chairman Pitts, Ranking Members Pallone and Green, members of the Committee, thank you for inviting me to attend the hearing today. My name is Dr. Jeffrey Lieberman, and I am the Lawrence C. Kolb Professor and Chairman of the Department of Psychiatry at Columbia University College of Physicians and Surgeons in New York. I also hold the title of Director at the New York State Psychiatric Institute and serve as Psychiatrist-in-Chief at the New York-Presbyterian Hospital - Columbia University Medical Center.

My 35-year career in psychiatric medicine has focused on research on the causes and treatment of schizophrenia and related psychotic disorders, and the care of patients. I have authored more than 550 articles published in the scientific literature and written and/or edited 16 books on mental illness and psychiatry including most recently Shrinks: The Untold Story of Psychiatry and personally treated or overseen the care of thousands of patients. I was honored to receive the Lieber Prize for Schizophrenia Research from NARSAD/Brain and Behavior Foundation, the Adolph Meyer and Research Awards from the American Psychiatric Association, the Research Award from the National Alliance on Mental Illness, and the Neuroscience Award from the International College of Neuropsychopharmacology. In 2000 I was elected to the National Academy of Sciences Institute of Medicine, and I am a past president of the American Psychiatric Association.

I am grateful for the opportunity to testify about mental illness and mental health care and the relevance of the Helping Families in Mental Health Crisis Act, H.R. 2646, introduced by Representatives Murphy and Johnson. First, I wish to provide the Committee with a short summary of my perspective on the current status of our nation in treating serious mental illness. Second, I wish to speak to several provisions of H.R. 2646 and how enactment of these provisions would significantly advance our approach to the treatment and care of serious mental illness. Finally, I wish to add some concluding thoughts on this Committee's work on the legislation, and encourage swift adoption of the Helping Families in Mental Crisis Act to allow me, and tens of thousands of

other health care professionals across the country, to better care for those suffering from serious mental illness and their families. We need to end the mental health crisis that exists in America today.

I. The Mental Health Crisis Facing America

I know that this Committee and the members of Congress are well aware of the mental health crisis facing this country, and I applaud Congressman Tim Murphy for all he has done to bring the facts to light on this issue, including the many hearings he has led. I also wish to thank Chairman Upton for his support of this effort, and also his leadership on the 21st Century Cures legislation which is so vital to those of us in the biomedical research community and the American population who benefit from progress in health care, as well as the other Committee Members for their contribution to making comprehensive mental health reform and enhancement of biomedical research a major focus of the 113th and 114th Congress.

Let me state at the outset that by mental illness I am referring to what are traditionally considered mental illnesses (e.g. schizophrenia, bipolar disorder, depression), addiction (e.g. substance use disorders) and intellectual disabilities (e.g. autism, Fragile X syndrome). The distinctions between these are arbitrary as they all are conditions affecting the same real estate in the brain and manifest by disturbances in common mental functions.

Many problems that you, as the leaders of our country, face are impossibly complex or require new knowledge to solve, such examples are Alzheimer's disease, terrorism and global warming. However, that is not the case with mental health. We have the knowledge and the means to do so much more. We simply lack the political and social will, which I fervently hope this committee will galvanize.

To understand the crisis in mental health care, we must view its historical context[1]. From the inception of psychiatry in the early 19th century until the 1950's, there was virtually no scientific understanding of mental illness or any effective treatments. The first effective treatments did not come until psychotropic drugs were discovered and introduced into clinical practice in 1955 beginning with antipsychotics and anxiolytics, and followed by antidepressants in the 1960's and mood stabilizers 1970's. Up until then, institutionalization was the primary mode of mental health care, apart from invasive and potentially dangerous treatments that were devised out of desperation such as Malaria Therapy, Coma Therapy, Electroshock Therapy and Pre-Frontal Leucotomy.

[1] Shrinks: The Untold Story of Psychiatry. Little Brown 2015

Following the advent of psychopharmacology came the development of scientifically proven forms of psychosocial treatments such as Cognitive Behavioral Therapy (CBT), Assertive Community Treatment, Supported Employment and Cognitive Rehabilitation, as well as neuromodulatory therapeutic devices including ECT, Repeated Transcranial Magnetic Stimulation, Transcranial Direct Current Stimulation and Deep Brain Stimulation, which comprised a broad array of effective and safe treatments for mental illness.

In 1955, when the first antipsychotic drug, chlorpromazine, was introduced, the population of institutionalized mentally ill persons in the U.S. (most of whom lived in appalling conditions) had reached its zenith (550,000 people). Our government's and citizens' humanitarian concerns combined with the newfound dramatic effectiveness of the miracle drugs inspired a grand plan for community based mental health care that was formalized in JFK's Community Mental Health Act of 1963. This historic initiative called for patients to be released from hospitals and be cared for on an outpatient basis at community mental health clinics. However, the resources, workforce and infrastructure of the state mental institutions were not transferred to the community settings, and, as a result, the deinstitutionalization movement was a catastrophic failure from which our society is still suffering. This is reflected in the large numbers of mentally ill persons who are homeless and incarcerated in

prisons, as well as by the epidemic of preventable and repeat hospitalizations (for psychiatric and medical reasons) that drive up health care costs.

Half-century later we are still fighting the same battle. Millions of individuals and their families across the country continue to struggle with preventable mental health crises. Approximately twenty million Americans suffer from serious mental illness, with almost 40 percent of these individuals receiving no treatment at all.[1] Prior to 1955 if you had a mental illness, the biggest barrier to relief from your symptoms was the lack of effective treatments. Currently, the greatest obstacles are lack of awareness, embarrassment and lack of access to effective care. Imagine an analogy to infectious disease in which large numbers of the U.S. population were suffering from pneumonia, tuberculosis, polio and AIDS and we were not using antibiotics, vaccines, antiretroviral drugs and protease inhibitors because of lack of awareness, fear or inability to find them. This is the situation we face with mental illness. Although our treatments are not perfect (they do not work for everyone and are not cures, and many medications and procedures do have side effects), they are highly effective and, when properly administered, are life changing and in some cases life saving.

There are two reasons for the peculiar situation in which we have effective treatments but are not using them. The first is stigma, which consists of ignorance and fear. Stigma of mental illness is pervasive in American society and is actively perpetuated by a virulent Anti-Psychiatry Movement. Psychiatry has the dubious distinction of being the only medical specialty with a movement dedicated to its eradication. (There are no anti-pediatrics, dermatology or orthopedics movements.) This movement is comprised by diverse constituencies who dispute the concept of mental illness and way to treat them including Scientology, the latter being motivated by financial designs rather than ideological reasons.

[1] **http://www.nejm.org/doi/full/10.1056/NEJMsa1413512**

The second reason is our country's failed mental health care and financing policies. Without discussing the myriad specific elements, the absence of an effective and enlightened policy has resulted in a fragmented and defective system that offers care which is limited, often incompetent and difficult to access.[1] The fact of the matter is that the workforce, infrastructure and financing mechanisms to enable the provision of comprehensive state of the art mental health care to the populations with mental illness are lacking.

While many agencies and stakeholder organizations and constituencies share responsibility for this shameful situation, SAMSHA's role is the most obvious. To say that this federal agency, most directly charged with

[1] **American Psychosis: How the Federal Government Destroyed the Mental Illness Treatment System. Oxford University Press 2014**

the delivery of quality mental health services to the American population, has failed miserably is an understatement. In fact I would go so far as to consider SAMSHA a proxy agency for the anti-psychiatry movement, which is to say that the agency has resisted the scientifically driven evidenced based approach to mental health care that psychiatric medicine has embraced since its scientific revolution began in the 1970's.

The combination of stigma and health policy failures has produced a staggering burden of mental illness, substance use disorders and intellectual disabilities on the individuals and families of this nation. Life expectancy among individuals with the most severe mental illnesses are reduced by 20 years, largely due to the combination of co-morbid medical conditions and addictions to which their mental illness makes them more susceptible, and increased suicide rates[1]. Mental illness costs this nation almost $500 billion each year, including lost earnings and productivity resulting from brain disorders[2]. For Medicaid patients, mood disorders and schizophrenia account

[1] JAMA Psychiatry. (2015). *Mortality in mental disorders and global disease burden implications: a systematic review and meta-analysis.* http://www.ncbi.nlm.nih.gov/pubmed/25671328

[2] NIMH. 2012. http://www.nimh.nih.gov/about/director/2015/mental-health-awareness-month-by-the-numbers.shtml.

for the top two conditions with the largest number of hospital readmissions[3]. Two million individuals with mental illnesses enter county jails each year and face minimal access to services[4].

Compounding this failure is the chronic underfunding of the NIH and its support of biomedical research. This has clearly impacted mental illness research, ranging from genetics to treatment interventions and services, which are predominantly funded through the NIMH. To illustrate, the federal budget this year is 4 trillion dollars, the NIH budget 32 billion and the NIMH budget 1.2 billion, while SAMSHA's budget is 3.6 billion. As NIH Director Collins stated last year was the darkest year ever for biomedical funding. Consequently, the advances that could have enhanced the quality of mental health care are being delayed and denied.

Our failure to take mental health care as an urgent public health need and national priority, has adversely affected our country in many ways, but there are several consequences which represent the tip of the iceberg of when it comes to our neglect of mental health care that are particularly disturbing. These begin with the seemingly recurrent incidents of mass violence in which the perpetrators are persons with untreated mental illness, and the shocking rates of suicide and PTSD in our military, but also includes domestic violence perpetrators and victims, the displaced mental patients who comprise 30% to 40% of the homeless and the growing rate of mentally ill prisoners. All of these would be limited or prevented by an effective mental health care system.

II. The Helping Families in Mental Health Crisis Act

[3] Healthcare Cost and Utilization Project. (2014). http://www.hcup-us.ahrq.gov/reports/statbriefs/sb172-Conditions-Readmissions-Payer.pdf

[4] Council of State Governments Justice Center. (2015). http://csgjusticecenter.org/mental-health/media-clips/national-effort-aims-to-tackle-mental-health-issues-in-county-jails/

Despite the challenging environment, which I have just described, I am optimistic that we can make significant progress and ultimately solve these problems. But, as a caregiver, researcher and administrator on the front lines of mental health care, I know that in order to do this we must have structural and regulatory reforms. For this reason I am pleased to have the opportunity to discuss and add my support of the Helping Families in Mental Health Crisis Act to the many others who have already endorsed the legislation. We all owe Representatives Murphy and Johnson our thanks for their leadership on this hugely important legislative initiative.

The legislation identifies and works to achieve several key objectives goals. First, it streamlines the federal agencies working on mental health issues to ensure better coordination among the numerous agencies that currently play a role in mental health care. It promotes the provision of evidence-based, science-driven treatment. It supports the research we need to develop treatments that build upon the incredible progress and advancements we've made in the field in the last several decades. It increases access to much needed integrated and innovative services.

More specifically, the legislation will achieve the following major changes:

- New Assistant Secretary: H.R. 2646 elevates mental health administration in the federal government by creating an Assistant Secretary for Mental Health and Substance Use Disorders within HHS who must be a highly qualified mental health clinician. A recent report from the Government Accountability Office (GAO) found that there was insufficient coordination across the 100+ major programs that focus on serious mental illness across the government. The proposed Assistant Secretary would address fragmentation of efforts and prioritize evidence-based, science-driven approaches to prevention, treatment, and recovery. H.R. 2646 would also transfer the duties of the Substance Abuse and Mental Health Services Administration to the proposed Assistant Secretary. More specifically, the legislation would transfer all personnel,

assets, and obligations of SAMHSA to the "Office of the Assistant Secretary for Mental Health and Substance Use Disorders".

I believe that this provision elevate and enhance the agency's impact by integrating it with an expert clinical framework across HHS. We should embrace the collection of what today are a disparate set of decentralized programs spread across multiple federal agencies into one, central coordination and policy implementation body, with clear responsibility to the Secretary for Health and Human Services. As this Committee is aware and as I have already referenced, several GAO reports have documented both the lack of federal coordination and the lack of program grant accountability in the mental health field. The proposed Assistant Secretary position would be a major step forward in addressing those issues, and having one accountable federal official who is answerable to you and America for the Government's actions in the area.

- Workforce Issues: H.R. 2646 includes numerous provisions that address the critical psychiatric and allied professional workforce shortage that individuals with mental illness face today. The legislation's proposed Assistant Secretary for Mental Health and Substance Use Disorders (ASMH), addressed above, would be tasked with the development of a "Nationwide Strategy" to increase the psychiatric workforce and recruit medical professionals for the treatment of individuals with serious mental illness and substance use disorders. This would be supported and evaluated by the proposed Interagency Serious Mental Illness Coordinating Committee. The Assistant Secretary must also prioritize workforce development for treatment and research activities that advance scientific and clinical understanding of mental health and substance abuse. Moreover, the legislation fixes barriers to loan repayment for child and adolescent psychiatrists through the National Health Service Corp.

These reforms are much needed – we need a combination of enhanced workforce and policies that facilitate team-based, collaborative care to meet treatment demands. Development of a deliberate and thoughtful national strategy is essential, and the expansion of the psychiatric

workforce needs serious attention. The legislation is a meaningful and important step in the right direction, and I commend the provisions to the Committee.

- Parity: The legislation would substantially improve enforcement of the Mental Health Parity Act by tasking the new Assistant Secretary with coordinating all programs and activities related to parity in health insurance benefits, by requiring annual reports to Congress on parity compliance investigations from federal Departments, and by having the Government Accountability Office investigate compliance of the parity law by health insurance plans. As the Members of this Committee know, the Parity laws have been on the books for years, yet enforcement is inconsistent. When enforcement does occur, it is not well known. The legislation would bring significant sunlight and transparency to the federal government's efforts in that regard, and help centralize, coordinate, and bring renewed focus to ensuring that the parity laws created by the Congress over the past several years are being implemented.
- Addressing HIPAA - The legislation would provide important clarity on how the HIPAA privacy laws work in the case of family members and caregivers who need access to treatment information about loved ones who are incapable of making informed decisions about that information disclosure – precisely because they are suffering the effects of serious mental illness. The legislation would permit disclosure of a limited set of protected health information to families and caregivers of individuals with serious mental illness if the disclosure meets a set of criteria that seeks to balance confidentiality considerations with the benefits of family and caregiver involvement in care.

Representative Matsui has introduced legislation, also before this Subcommittee today, on the same issue, and I commend the Congresswoman on her leadership and thoughtfulness on mental health issues. However, from my perspective, today's laws are unclear, unhelpful, and widely misunderstood and misapplied. Thus, I urge this Committee, however it considers these

two important proposals, to act with all due speed in fixing this problem which plagues thousands of families across the country.

- Assisted Outpatient Treatment: The Helping Families in Mental Crisis Act also provides a flexible requirement for proposed state assisted outpatient treatment (AOT) requirements. This Committee should be aware that 45 states already have some form of AOT laws on their books. The legislation creates appropriate financial incentives for states to adopt and implement these laws, while leaving states with the flexibility to define treatment standards.
- Medicaid Provisions. The legislation partially removes some of the unfortunate legacy provisions of the so-called "IMD Exclusion" which were added to the Medicaid laws decades ago and cause a real shortage of inpatient beds across the country. This bill would also eliminate the so-called "190 day limit" which set a cap on the number of inpatient treatment days for which Medicare may currently pay. H.R. 2646 also includes important provisions to discourage states from potentially shifting costs to the federal government as a result of new Medicaid financing for psychiatric hospitals.

While I wanted to highlight these provisions for the Committee in my testimony, there are also numerous other important proposals in the legislation. Some of these were carried over from H.R. 3717 (113th Cong.), the similar legislation introduced in 2014 by Representatives Murphy and Johnson. These include:

- Many new programmatic requirements that promote evidence-based, science-driven policies and practices and requirements that foster integration of psychiatric services;
- A meaningful increase in authorized funding for National Institute of Mental Health research into determinants of self and other-directed violence, as well as for the BRAIN Initiative;
- The creation of a National Mental Health Policy Laboratory to test and implement innovative MH/SUD delivery models;

- The creation of an Interagency Serious Mental Illness Coordinating Committee that consists of both public and private members to study federal serious mental illness research and service delivery efforts and make recommendations on the same;
- Expansion of Medicaid coverage of so-called "same day billing" of mental health and primary care services in certain facilities, and expansion of both Medicaid and Medicare coverage of psychiatric medications;
- The extension of Medicaid and Medicare incentives for HIT adoption to mental health and addiction facilities that are currently ineligible;
- Reauthorization of the Garrett Lee Smith Memorial Act (suicide prevention supports and grants); and Provisions providing grants for primary care mental health training and tele-mental health provision.

III. H.R. 2646 -- Comprehensive Mental Health Reform

In summary, I would like to express my sincere appreciation and admiration of the Committee and Representatives Murphy and Johnson for introducing and hopefully enacting this legislation. The crisis in mental health care is a cancer in our country but one that can be cured. We have the knowledge and the means to succeed; we simply need to have the will and commitment to apply them. The benefits of such an initiative would be enormous. So many painful and dispiriting elements and incidents in our society would be ameliorated by the advent of a comprehensive effective public mental health system and have a dramatically uplifting effect on public morale and quality of life.

I cannot overstate how devastating the mental illness crisis is to this country and how our policies heretofore have perpetuated this problem. The lack of an enlightened comprehensive mental health care policy adequately resourced has caused untold pain and incurred exorbitant costs to the U.S. At the same time the underfunding of biomedical research has stifled progress and innovation in health care, and is eroding our

countries academic medical infrastructure and workforce. The pending legislation would constitute an important first step in correcting these problems.

While my testimony above enumerates many of the specifics of the legislation, I would note that each of these provisions, on their own, would be worthy of this Committee's attention, and of enactment through legislation. However, the combination of these changes in a single bill truly makes the Helping Families in Mental Health Crisis Act worthy of the label of "comprehensive mental health reform." H.R. 2646 is truly that – comprehensive in scope, and comprehensive in addressing the changes that need to be made to reform our nation's mental health system.

To that end, I wish to thank Representatives Murphy and Johnson for their leadership in calling attention to the importance and seriousness of these issues. Congressman Murphy in particular has been tireless in his efforts to convene Congressional hearings, briefing sessions, and reaches out to the entire range of stakeholders to understand the proposed legislation and actively support it. Our being here today bears witness to his work. While I understand that today's hearing is the first step in the legislative process, I urge the Committee to act with all due haste to support and bring this important legislation to the entire Congress. Millions of Americans are counting on it.

Mr. Chairman and members of the Committee, as a treating physician, I witness firsthand the numerous challenges faced by both patients and their families in navigating today's mental health care system. I am confident that the changes proposed in this legislation will have a meaningful and positive effect on those suffering from mental illness in America today. Passage would be provide enormous benefits to families in mental health crisis today and be a boon to our country. I thank you for your consideration of this testimony, and welcome any questions that you may have for me.

Mr. PITTS. The chair thanks the gentleman.

I now recognize Mr. Gionfriddo for 5 minutes for an opening statement.

STATEMENT OF PAUL GIONFRIDDO

Mr. GIONFRIDDO. Thank you. I want to applaud this subcommittee, and in particular, Congressman Tim Murphy and Congresswoman Eddie Bernice Johnson, for your leadership in this area.

As a parent of an adult son with schizophrenia, I deeply appreciate this because for so many of us, this is not just a policy matter, this is our life.

As a former state legislator in Connecticut, I know how difficult it can be to build consensus around mental health policy. I, therefore, also appreciate the effort of the sponsors to invite so much feedback during the past year to use it to shape the proposal before you today. In our view, H.R. 2646 is an important start to making comprehensive mental health reform a reality in America.

In these brief remarks, let me focus on some areas that are important to MHA. Its emphasis on moving upstream in the process, that is, on intervening before stage 4, is a critical step forward to treating mental illnesses like we treat every other chronic disease. It includes funds for screening, early intervention, and treatment programs. And let me share why this is so important. In the spring of 2014, MHA launched an online screening tool through our Web site at MHAscreening.org. To date, nearly ½ million screens have been completed; nearly ½ by people under the age of 25. Two thirds screen as positive or moderate to severe for the condition for which they have screened, but ⅔ of those say they have never been diagnosed with a mental health condition. Screening is the doorway to services and treatment. H.R. 2646 makes screening, especially for children and young adults, a part of the innovation grants, the demonstration grants, the Youth Suicide Prevention Program, the Campus Mental Health Program, among others. And in legislation that emphasizes building on evidence-based programs, we note the importance of innovation, because today's evidence-based program is yesterday's well-evaluated innovation.

In addition, it is our hope that you will look to expand the opportunities to integrate health and educational services for our children. My son, Tim, has schizophrenia. He is 30 years old today, living mostly on the streets of San Francisco. He first showed signs of the disease when he was a young child. Throughout his school years, we sought special education services for him, and were frequently rebuffed. This is because those of us making policy a generation ago were not thinking about children like Tim as we implemented our modern special education laws. Today, only 362,000 children in the country receive special education services because of an SED label. That represents only 1 child in every 28 NIMH says has a serious mental health condition or concern. This represents too many tragedies waiting to happen.

MHA endorses the empowerment and elevation of the lead federal agency in this legislation, and we hope you will consider adding two additional responsibilities to it. The first would be to establish a common standard, other than danger to self or others, as a

trigger to involuntary treatment for SSI, because this is not a clinical standard. The second would be to develop a national plan that would result in an end to the incarceration of nonviolent people with serious mental illnesses. We also endorse the efforts to enhance the mental health workforce in this bill. At MHA, we have a special interest in the peer. And in this legislation, we see an opportunity to develop a properly credentialed peer workforce that could work competitively at competitive salaries in clinical settings.

With respect to AOT, we support the approach in this legislation that it takes not to mandate it nationwide. We encourage the committee's review of language that may appear to be in conflict with the intent of the sponsors, and revise it if need be. And we also support changes to the privacy rules, because the current rules are an impediment to integrating health and behavioral health care. You can't fully integrate care with only ½ a medical record. But as someone who has worked closely in the past in Austin, Texas, with community-based providers seeking to integrate care, I worry that meeting simultaneously the six conditions may be so difficult and time-consuming for providers that many will not try.

Consider as an alternative this. Clarify the relevant law to eliminate the super authorization needed to share behavioral health information. This will promote integration without compromising an individual's right to manage the release of his or her protected health information. Finally, we understand the need to offset new expenditures with reductions in other areas, but worry that the offsets might come from existing community health programs. If you want to find offsets, please look towards jails and prisons. By sending so many of our children, like my son, Tim, to those 21st century asylums, that is where we sent the funding we need for mental health services today.

In closing, for more than a century, MHA has argued, for more than a century, that it is well past time to address mental health issues in a comprehensive, thoughtful way, and this is a start. Let's work together to remove the stigma associated with seeking help for mental health concerns, and the discrimination that occurs against those who live with them. Let's put in place a mental health system that allows us all to move upstream, provide the behavioral health services individuals need and deserve early, and enforce parity in coverage. Let us address mental health concerns before stage 4.

Thank you.

[The prepared statement of Mr. Gionfriddo follows:]

Statement of Paul Gionfriddo, President and CEO of Mental Health America

U.S. House of Representatives Committee on Energy and Commerce,

Subcommittee on Health

Regarding HR 2646, The Helping Families in Mental Health Crisis Act of 2015

June 16, 2015

Summary

H.R. 2646 is an important start to passing comprehensive mental health reform in America. Its emphasis on moving upstream in the process – i.e., on intervening before Stage 4 – is a critical step forward toward treating mental illnesses like we treat every other chronic disease in America.

As it stands, HR 2646 addresses five fundamental areas of mental health: Promote screening and early intervention, build community-based systems of care, enhance the behavioral health workforce, Integrate health and behavioral health care, and enforce parity in coverage of health and behavioral health services. All are critically needed.

It appropriately emphasizes screening, secondary and tertiary prevention, and integration, while creating a stronger central federal authority to advance mental health policy. It focuses resources on meeting the needs of children and young adults. This testimony makes recommendations for building out those areas. It promotes both innovative programming and the replication of evidence-based models. It underscores the importance of evaluation. It recognizes the importance of protecting the legal rights of people with mental illness, making some revisions to HIPAA, and moving treatment and services from jails to communities. This testimony includes recommendations for changing HIPAA standards to promote integration. It includes peers as an important part of the future behavioral

healthcare workforce, working in clinical settings – and this testimony includes some recommendations for making that happen.

We recognize that the legislation in its current form is not a finished product and that it will be changed and amended as it moves through the legislative process. So long as it continues to emphasize prevention strategies, early identification and intervention, integration of health, behavioral health and other services, and lay the groundwork for recovery, we believe we and others will be able to support it fully.

Statement of Paul Gionfriddo, President and CEO of Mental Health America

U.S. House of Representatives Committee on Energy and Commerce,

Subcommittee on Health

Regarding HR 2646, The Helping Families in Mental Health Crisis Act of 2015

June 16, 2015

Mr. Chairman, Ranking Minority Member Green, members of the Subcommittee on Health, my name is Paul Gionfriddo, President and CEO of Mental Health America, the nation's leading community-based non-profit dedicated to helping all Americans achieve wellness by living mentally healthier lives. Thank you for the opportunity to testify regarding H.R. 2646, The Helping Families in Mental Health Crisis Act of 2015.

We applaud this subcommittee, and, in particular, Congressman Tim Murphy and Congresswoman Eddie Bernice Johnson for their bipartisan leadership. As a parent of an adult son with schizophrenia, and as a former mayor and state legislator in Connecticut, I know how difficult it can be to reach across the aisle, identify consensus and pass meaningful legislation, particularly on an issue as thorny as mental health. We appreciate the efforts of the sponsors to take into consideration all the feedback they received from us and others throughout the year – and to change so many of the provisions that deeply worried people living with mental illness and working toward recovery.

I will not cover the entire proposal in these brief remarks, but will focus on some of the areas that are important to us.

H.R. 2646, while not perfect, is an important start to passing comprehensive mental health reform in America. Its emphasis on moving upstream in the process – i.e., on intervening before Stage 4

– is a critical step forward toward treating mental illnesses like we treat every other chronic disease in America, and toward changing the trajectories of lives impacted by illnesses that people acquire – most frequently during childhood – through no fault of their own.

As it stands, HR 2646 addresses five fundamental areas of mental health: Promote screening and early intervention, build community-based systems of care, enhance the behavioral health workforce, Integrate health and behavioral health care, and enforce parity in coverage of health and behavioral health services. All are critically needed.

Mental Health America has some concerns, which I will address shortly. We recognize that the legislation in its current form is not a finished product and that it will be changed and amended as it moves through the legislative process. We are hopeful that today is the start of an ongoing conversation among all of us—policymakers, providers, and advocates—to address concerns and improve upon this critical legislation. So long as it continues to emphasize prevention strategies, early identification and intervention, integration of health, behavioral health and other services, and lay the groundwork for recovery, with thoughtful consideration of amendments, we believe Mental Health America and others will be able to support it fully.

Screening and Early Intervention

The proposed legislation includes funds for early childhood intervention and treatment programs and for longitudinal studies of their effectiveness. However, these are currently limited to no more than three programs nationwide. Mental Health America would prefer a larger program, so as to open the door to additional programs should more funding become available.

Because serious mental illnesses frequently emerge during childhood, services to children and young people must be emphasized in any reform legislation. HR 2646 puts some needed focus here. In the innovation grants, it directs at least one-third of all the dollars to screening and early intervention

services to people under the age of 18. And in the demonstration grants program, half of the dollars are directed to people under the age of twenty-six.

In the spring of 2014, Mental Health America launched online screening tools through our website at www.mhascreening.org. To date, nearly one half million screens have been completed. Nearly half of those who complete a screen are under the age of 25. Two-thirds of those completing screens have screened as positive or in the moderate-to-severe range for the conditions for which they have screened. But two-thirds of those indicate that they have never been diagnosed with a mental health condition.

Just as we do with every other chronic condition, we frequently reach people initially through screening. In the proposed legislation, there is a welcome emphasis on screening and early intervention – in the innovation grants, the demonstration grants, the youth suicide prevention program, and the campus mental health program, among others. And in legislation that frequently emphasizes both evaluation and building on evidence-based programs, we appreciate the setting aside of dollars for innovation – because today's evidence-based program is yesterday's well-evaluated innovation.

There is an additional opportunity here that we would hope the committee will consider – and that is to make changes to the EPSDT program, and to the essential health benefits, to guarantee that services that are identified as needed in response to screening are covered fully by public and private insurance.

In addition, it is our hope and mine personally that at some point during this process, members of Congress will consider the importance of integrating health and educational services for our children. My son Tim has schizophrenia. He is thirty years old today, living mostly on the streets of San Francisco. He first showed signs of the disease when he was a young child. Throughout his school years, we sought to gain special education services for him and were frequently rebuffed by school districts.

At the time – this was in the 1990s – I had a friend and colleague who had worked on writing the regulations for what would become the Individuals with Disabilities Education Act (IDEA). I once asked him, referring to Tim, "is this who you had in mind when you wrote those rules?" "Paul," he replied, "we were thinking of kids in wheelchairs." As a result, we did an outstanding job of integrating children with significant physical disabilities into regular educational environments, enabling them to live productive lives as adults. But we didn't do so well with children like Tim. Today, according to US Department of Education data, approximately 375,000 children in the country receive special education services because of an "SED" label. That represents only one child in every 28 that the National Institute of Mental Health (NIMH) says has a "serious" mental health condition or concern.

There are many ways we could tackle this. The most obvious and money-saving would be to amend the special education law to permit IEP-mandated services to be paid for by health insurance as a payer of first resort, so that school districts could reserve their limited special education funds for services that can't be paid for through another funding source. That way, schools wouldn't be so reluctant to include the kinds of community-based clinical services in an IEP that children like my son Tim need to succeed.

The New Federal Agency and the Interagency Serious Mental Illness Coordinating Committee

Mental Health America endorses the additional empowerment and elevation of the lead federal behavioral health agency in this legislation, and the creation of the Interagency Serious Mental Illness Coordinating Committee (ISMICC). MHA has supported SAMHSA, and believe that it has done commendable work with very limited resources. But our nation's mental health needs are so critical that federal leadership in this area must be enhanced and better centralized. We look forward to working with members of Congress to make certain this new agency is as successful as it can be.

While the responsibilities being assigned to the Assistant Secretary and the ISMICC are appropriate, there are two others not in the proposal that we would ask you to give to them. The first

would be to establish a common standard other than "danger to self or others" as a trigger to treatment for SMI, because this – while a popular standard in wide use – is not a clinical standard. The second would be to develop a national plan that would result in an end to the incarceration of nonviolent people with serious mental illnesses within a decade.

Peer Workforce Development

We endorse the intent of this bill to enhance the mental health workforce. At Mental Health America, we have a special interest in the peer workforce. Many of our affiliates around the nation are direct service providers and have done outstanding work in developing and supporting the peer workforce in general, non-clinical settings. In this legislation, we see an opportunity to develop a properly-credentialed peer workforce that could work competitively in clinical settings, too.

We have been working with Kaiser Permanente on a pilot this year. We train the peers and along with our local MHA affiliates provide oversight and supervision. The work of the peers is directed (and supervised day-to-day) by the clinical professionals on whose team they work.

Mental Health America believes that the draft language in HR 2646 should be strengthened to promote the inclusion of properly trained and supervised peers on clinical care teams, and should focus on this in particular. I have submitted suggested draft language in Attachment 1.

Assisted Outpatient Treatment

Mental Health America has not supported a national mandate to states to enact Assisted Outpatient Treatment (AOT) laws, nor do we support state laws that do not include additional dollars for community outpatient services. Our position on AOT, adopted unanimously by our Board of Directors in March 2015, is that it should be used "only as a last resort," (Position Statement 22) in a limited way, and only when there are adequate local services to serve the needs of everyone who wants to access them voluntarily.

We therefore support the approach this legislation takes not to mandate AOT, but to give states that have AOT laws a 2 percent funding enhancement. AOT should continue to be a choice made by states, not mandated by the federal government, and sections in this legislation that appear to be in conflict with this should be reviewed and revised if need be.. And those that choose to enact AOT should be required to evaluate the effectiveness of their programs and to demonstrate that they have used their new dollars to enhance community-based systems of care.

HIPAA

We support the loosening of HIPAA rules in Section 401, because these rules need to be changed if we are serious about integrating health and behavioral health care. HR 2646 takes one very limited step toward allowing information to be shared more freely. It spells out six conditions that must be met for information to be shared with a caregiver, who can then share it with a provider on behalf of a patient. It may be exceedingly difficult and time-consuming for a provider or provider entity to prove that all these conditions are being met simultaneously. So they may not even try.

I worked on behalf of a community health collaboration in Austin TX from 2001 to 2005. One of our projects was to implement a shared electronic health record among more than two dozen provider locations. We learned what everyone learns who tries to integrate care – it can't be done with only part of a health record. If a provider relies on an incomplete record to make decisions about care, he or she does so at his or her own peril – and at the peril of the patient as well.

In our Position Statement 27, Mental Health America lays out the problem:

> The federal government and some states have identified information that should be MORE PROTECTED than other information covered by HIPAA. MHA generally opposes special protections of this kind because there is no evidence that additional formalities actually increase privacy, and such special protections compromise integration of care. Examples of "super-confidential" information include: genetic information and information pertaining to school

records, substance abuse, mental health conditions, HIV testing, and sexually transmitted diseases, as defined and protected by specific federal and state laws and regulations. MHA does support the HIPAA exemption for psychotherapy notes, as defined in 45 CFR 164.501.

There are other proposals before your committee that also seek to address this matter. One proposal suggests as an alternative that we look again at the guidance for sharing offered last year to providers, to see whether some of this guidance should be codified. Another may favor a time-limited authorization for the sharing of some behavioral health data.

Here is what we would suggest. If we are serious about integrating health and behavioral health care, then the goal here should be easier sharing of information among providers. The only way to do this is to clarify the law to eliminate the "super authorization" needed to share behavioral health information.

What is more, while promoting integration making this change will still give the individual the right to control the release of his or her protected health information.

Protection and Advocacy Services for Individuals with Mental Illness

HR 2646 retains funding for Protection and Advocacy Services. We support this. It also proposes to focus these services "exclusively on safeguarding rights to be free from abuse and neglect." We at MHA are concerned that the final statement of scope for needed protection and advocacy services may be too narrowly drawn to fully protect the rights of all people with mental illness. I hope and believe that someday soon my son Tim will decide to leave the streets and re-engage with society. When he does, I have no doubt that he is going to have to rely on effective legal counsel to obtain the housing, employment, and the supports he will need.

Budget Neutrality

We understand the constraints under which members of Congress work. We applaud the effort to manage the loosening of the IMD exclusion to make it budget neutral and look forward to discussing

this further as the details of the approach emerge. And we understand the need to offset new expenditures with reductions in other areas. I want to note that many advocates are worried that members of Congress will find the offsets to support new programs in this legislation from existing community mental health programs, resulting in the loss of programs around the country that are lifelines to people with serious mental illness.

We do not believe that is the intent of the sponsors and want to state emphatically that we at Mental Health America would not support this either. These programs have been underfunded for too long already, and HR 2646 takes some first tentative steps toward remedying this situation. If you want to find offsets, please look to our jails and prisons. By sending so many of our children like my son Tim to those 21st Century asylums, that's where we've put the funding that could be used to support the community-based initiatives in this legislation and more, and that's why we have yet to address the fundamental issues facing so many of our children like my son Tim.

In closing, for more than a century Mental Health America has appreciated that addressing mental health and illness is a complex and emotional issue. But it is well past time to address them in a comprehensive, thoughtful way. We must work together to remove the stigma associated with seeking help for mental health concerns, and the discrimination that occurs against those who live with them. We must put into place a mental health system that allows us all to move upstream, provide the behavioral health services individuals need and deserve early, and enforce parity in coverage. We must address mental health and mental illness before Stage 4.

Thank you for the opportunity to testify before you today and I am happy to take any questions you may have.

Attachment 1

Peer Support Specialist

(2) Peer-Support Specialist Defined. In this subsection the term "peer-support specialist" means an individual who-

A. Has made a commitment to his or her own recovery from mental illness or substance use and uses their lived experience plus skills learned in formal training to facilitate support groups, act as a systems navigator, mentor, educator, advocate, and work one on one with individuals living with a mental illness or a substance use disorder. When working in a clinical setting they work in consultation with a licensed mental health or substance use treatment professional, and are supervised by an administrator trained in the concepts of recovery and peer support with the oversight of a licensed professional. When working in a peer-run program they are supervised by a peer administrator with access to a licensed professional when needed;
B. Has been an active participant in mental health or substance use treatment;
C. Does not provide direct medical services;
D. Does not perform services outside of his or her area of training, expertise, competence, or scope of practice.

(3) Contents, - Each report under this subsection shall include information on best practices with regard to the following:

A. Hours of formal work or volunteer experience related to mental health and substance use issues.
B. Types of peer specialist exams required.
C. Code of ethics.
D. Additional trainings required prior to certification, including areas such as –
   i. Integrating physical medicine and mental health supportive services;
   ii. Ethics;
   iii. Scope of practice;
   iv. Crisis intervention
   v. Identification and treatment options of mental health disorders;
   vi. State confidentiality laws;
   vii. Federal privacy protections, including under the Health Insurance Portability and Accountability Act of 1996; and
   viii. Other areas as determined by the Assistant Secretary in consultation with peer support experts.

E. Requirements to explain what, where, when, and how to accurately complete all required documentation activities.

F. Required or recommended skill sets, including:
   i. Helping consumers identify risk indicators, including individual stressors, triggers, and

indicators of pre-crisis symptoms;

ii. Explaining basic crisis avoidance techniques;

iii. Explaining basic suicide prevention concepts and techniques;

iv. Identifying and responding appropriately to personal stressors, triggers, and indicators;

v. Effective listening techniques

vi. Identifying an individual's current stage of change or recovery

vii. Teaching individuals how to access or participate in community mental health and related services;

viii. Developing pre-crisis, crisis, and recovery plans; and

ix. Identifying circumstances when it is appropriate to request assistance from other professionals to help meet the individual's recovery goals.

G. Requirements for continuing education credits annually

Mr. PITTS. The chair thanks the gentleman.

I now recognize Mr. Coe 5 minutes for your opening statement.

STATEMENT OF STEVE COE

Mr. COE. Chairman Pitts, Congressman Murphy, thank you very much for inviting me to come today. It is a very important legislation, and I congratulate you for your vision.

As you can see from my resume, I have worked as a CEO at the same agency, Community Access, for almost 36 years. I like to tell people I may have worked here a long time, but I have had the same job for only 1 day. For instance, I wasn't testifying before Congress yesterday. Next week, I will be at a conference in Norway, learning about assertive community outreach programs in Europe. And with hundreds of employees, and 11,000 tenants in 20 apartment buildings from the Bronx, Manhattan, and Brooklyn, something different is happening every day.

Most of what happens at Community Access is inspiring, which is another reason I have worked here so long. As my submitted testimony describes, our organization was founded by family members, led by the brother of a woman who had spent years confined to psychiatric hospitals, and then more years cycling between squalid housing and more hospital wards. His name was Fred Hartman. Fred inspired me, when I met him as a graduate student, studying housing and service models that would break the revolving door cycle, common in the 1970s when states discharged thousands of patients into our communities without proper supports. Fred's day job was Editor of Natural History Magazine, but he was really an activist and an organizer. As a white New York City kid, he had gotten on a bus and went to help black Americans vote in the south. When faced with the human misery and injustice experienced by his own sister, he recruited friends and colleagues, and created a better mousetrap; an improved model of care that would give former patients a safe, stable, affordable home, and basic supports.

Community Access started out renting apartments in rundown tenement buildings. Today, we build modern apartment buildings with amenities like free Wi-Fi, 24/7 front desk service. But the core elements remain the same. People choose their own apartments and who they want to live with. They sign leases, they are responsible for their own bills. And our buildings integrate affordable housing for families and children, with units for formerly homeless people recovering from mental illness, referred directly from the New York City shelter system. We even have a subsidy program to encourage pet ownership.

Overall, I feel H.R. 2646 supports many of the principles we embrace; an emphasis on results and outcomes, recognizing the valuable role peers can play in the workforce, support for innovation and demonstration projects to test new ideas, and more. But while there is a lot to like in H.R. 2646, the principle vehicle offered to achieve these results, AOT, is not what Fred would do. He believed too strongly in human rights and social justice; passions that I share. We can all agree our system of care fails on many fronts, and nowhere more than in the provision of crisis services and supports. H.R. 26 acknowledges this fact within the title of the bill, to

make supportive services available to individuals and families in mental health crisis.

H.R. 2646 doesn't spell out what these supports should look like, which makes potential supporters of reform legislation, like myself, extremely wary. AOT is not a defined service. I can mean anything, and not much at all. In New York City, for instance, an AOT-assigned individual is given priority access to supportive housing, which research shows is the most effective tool in promoting community stability, and is entirely absent in many places.

What service is going to take its place if this person in crisis is homeless? A higher dosage of medication, a 15-minute visit to a psychiatrist, a hospital bed? Without standards, AOT can mean anything, including interventions that have no evidence-base whatsoever.

If we want true reform, let's mandate specific interventions that we know work, and many of which are mentioned in H.R. 2646. Mobile crisis teams, crisis intervention training for first responders. Only 3,000 of the Nation's 18,000 police departments use this commonsense approach. Patient-centered treating planning, targeted case management, psychiatric rehabilitation services, which is evidence-based, peer support and counseling services. Adding a guaranteed housing subsidy, and there have been cutbacks continually in Section 8 at the federal level, 24/7 walk-in centers, peer-operated support lines, like we operate with the Parachute NYC Program, and reform to the Ticket to Work Program so it actually becomes a pathway to a job, would truly transform the lives of millions of Americans with mental illness.

States are already mandated to provide many services, including public education and prisons. How fervently they have chosen to embrace these mandates and fund them varies widely, and there is no reason to expect a vaguely defined mandate for an AOT program would turn out any better.

Health care reform, with an emphasis on preventive services, integrated physical and mental health care, and crisis supports to avoid costly and traumatic hospital care, is already driving reform efforts across the country. H.R. 2646 should look to support what is already happening in the marketplace, and not place another unfunded mandate on our State governments.

Thank you.

[The prepared statement of Mr. Coe follows:]

United States House of Representatives
Committee on Energy and Commerce
Subcommittee on Health
"Examining H.R. 2646, the Helping Families in Mental Health Crisis Act."

Testimony of
Steve Coe, CEO, Community Access, Inc.
2 Washington Street 9fl NY, NY 10004
212.780.1400 x7711; scoe@communityaccess.org

June 16, 2015

Thank you Chairman Pitts for giving me this opportunity to appear before your committee.

Before I address the particular issues related to H.R. 2646, I'd like to take a moment to tell you a little about Community Access and why I think our experience has something to offer your committee as it deliberates the merits of this important piece of legislation.

The Community Access: Mission, Values and Programs

Community Access founded in 1974 by parents and relatives of people with mental illness who had been long-term patients in state psychiatric facilities. As our name implies, the focus of the program was, and remains, to assist people find a meaningful role in the broader society.

Our founders were mostly associated with Manhattan Psychiatric Center, a 5,000 bed facility located on an island in New York City's East River. At the time, New York, like many states, had adopted a policy of deinstitutionalization, which encouraged the discharge of long-term patients into the community, many who had never lived independently and were poorly equipped for this sudden transformation in their lives.

The outcomes from this policy, we now know, were tragic. Former patients often became homeless, or if they were fortunate, found housing in squalid rooming houses or, in the case of New York City, massive single room occupancy hotels. Without any supports or access to basic resources, the former patients became frequent users of emergency care, jails, and the newly-expanding homeless services system.

Community Access' solution was simple: to provide a safe place to call home, combined with caring supports to insure tenants had enough to eat, proper medical care, and a daily routine that promoted some semblance of a "normal" life. Because we lacked funds to hire more than two staff, the "support services" were the roles played by our friends and neighbors every day: fellow tenants helped each other out in big ways and small, from shopping and cooking, to providing leads for jobs or other community resources.

Today this model has evolved into what we call supportive housing, but at the time it was a unique and compelling social experiment, especially for a young graduate student like me. After writing a paper about Community Access as part of a research project, I offered my services as a summer intern in 1979 and became the agency's second staff member.

Our mission has remained steady for 41 years, while the scope and methods evolved over time. The original apartments in run-down tenements on Manhattan's Lower East Side have been replaced by modern apartment buildings. Our twenty projects now provide housing for over 1,100 tenants. However, the lessons learned from those early days have been incorporated into everything we do today.

First, our buildings are mostly "integrated," by including both units for formerly homeless adults with mental illness, but also families with children and others who simply need an affordable home. We encourage tenants to adopt pets and provide 24/7 front desk service. Our buildings also include amenities like free WiFi, on-site laundry facilities, computer labs, and community space for special events and meetings.

Most importantly, we rigidly separate our dual roles as landlord and service provider. Accepting or using services is not a prerequisite for living in our housing. All tenants sign leases and agree to abide by standard house rules that are common to apartment buildings in the city. Tenants pay their own rent, electric, and other bills. In short, they treated like responsible adults.

By contract, referrals for our special needs units come exclusively from the New York City's Department of Homeless Services, with a priority given to long-term shelter stayers and homeless veterans. We have a housing first philosophy, which means no referral is rejected because the person is not deemed "ready" for housing.

Community Access Staff

Support staff work in most of our buildings and tenants often seek their assistance to manage the many complicated issues in their lives. This can be related to finances, work, or follow up medical care. Who these support staff are and how they are recruited and trained is a key factor in our success.

In 1993 we made a decision to affirmatively hire individuals had a lived experience with the mental health system. We do this by affixing the following statement to all job announcements:

> "Community Access is an Equal Opportunity Employer and is committed to the hiring of at least 51% consumer staff, in all of its departments and programs, and at all levels of management."

This policy has created a work environment and culture that, we believe, more is sensitive to the needs of the people we help and has led to the creation of some innovative programs, including a peer training academy, peer-run crisis services, and advocacy efforts to expand housing and reform criminal justice services.

The Howie the Harp Peer Advocacy and Training Center

The Howie the Harp Center was created by Community Access' first director of advocacy, Howard "The Harp" Geld, in 1995 to help users of mental health services become providers of

services. Howie's vision was to create a defined role for peers in the workforce and to do this through a comprehensive training and internship program. Howie died of a heart attack two weeks before the first class was to meet and the program was named in his honor.

Twenty years later, the Center has expanded from an initial class of ten students to two semesters per year with 40 students each, all of whom must have an Axis I diagnosis to be eligible. The training includes 450 hours of classroom instruction[1] followed by a three-month internship at a human service agency, which can be anything from a drop-in center, to a hospital or clinic. It is a rigorous program, but over 50% of the people who start the program graduate and find employment and a career path in the helping professions.

Crisis Alternatives and Parachute NYC

It has long been a goal of Community Access to create programs and services that would replace the standard care people receive during a psychiatric/emotional crisis. It has been our experience that this care, which usually involves the use of police officers, handcuffs, confinement in a facility, and high doses of medication, is traumatic for the individual and does not promote long-term recovery. It also extremely costly for the taxpayer, especially if the person being helped suffers a relapse and repeats the cycle, which is often the case.

After extensive research, we drafted a report and several business plans to create a crisis alternative to hospitalization program (Access to Recovery), but we were continually frustrated by the lack of public funding for what we knew would be a more cost-effective approach.

In 2011, we finally saw a funding opportunity when the Centers for Medicare & Medicaid Services announced the availability of Health Care Innovation Awards that were designed to support "..the most compelling new ideas to deliver better health, improved care and lower costs to... those with the highest health care needs."[2] We approached the City of New York about responding to this program and the result was a successful application[3] to create Parachute NYC.

> "Parachute NYC is a citywide approach to provide a "soft-landing" for individuals experiencing psychiatric crisis. This new program offers community centered options that focus on recovery, hope and a healthy future. Parachute NYC uses mobile treatment teams, crisis respite centers, and a peer operated Support Line to provide early engagement, continuity of care and combined peer and non-peer community service, thus shifting the focus of care from crisis intervention to long-term, community-integrated treatment with access to primary care, improving crisis management and reducing emergency room visits and hospital admissions."[4]

Community Access has a three-part role in the overall Parachute project: open the first peer-operated respite center in Manhattan, launch the peer-operated support line, and provide

[1] An outline of the class schedule is included as an attachment to this testimony
[2] http://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/
[3] Submitted as an attachment to this testimony
[4] http://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/New-York.html

enhanced training through the Howie the Harp center to expand the peer workforce.

In August 2012 we began advertising for people with a "lived experience" to work at the respite center. We had 14 respite positions, plus 5 positions for the support line, which would operate out of the respite center from 4 pm to midnight. We received 800 applications for these 19 positions. By October 2012 we were fully staffed and training began in two primary methodologies: Intentional Peer Support[5] and Need Adapted Treatment (also known as Open Dialogue)[6].

The Crisis Respite Center

In January 2013, we opened the Manhattan Crisis Respite Center[7] at 315 Second Avenue. As with any new service introduced into an established system, it took a number of months before referrals from providers and families began with regularity. In the first five months of operation, there were only 13 guests and a 12% occupancy rate. However, during the most recent five-month period we had 100 guests and a 70% occupancy rate. The average length of stay is 7.5 days.

It's important to note that the largest single source of referrals (25%) is "self-referrals," which the majority of the time means a family member or friend has contacted us. About 45 of the 370 total guests have been repeat users, and fewer than a dozen people have come more than twice.

"Treatment" at the respite center follows the principles of Intentional Peer Support and common sense practices to ensure the guests and staff remain safe. If we don't know prospective guests, we ask that they secure a letter from a treating professional that states they are not a danger to self or others. We do not create a treatment plan or conduct psychosocial assessments, although we maintain linkages with mobile health and mental health teams in case we suspect someone needs immediate attention. Guests bring, use, and store their own medications.

Unlike a hospital setting, guests are free to come and go, use computers and phones provided in the common area, and, in some cases, even bring their pet or service animal. A washing machine and dryer are provided and guests are expected to maintain their personal space.

The initial focus when a guest arrives is to make him or her feel safe and relaxed. This might take a day or so, but guests quickly adapt to the new routine. Morning and mid-day meals are the guests' responsibility. We provide a well-stocked pantry, but guests may buy and store their own food. Dinner is a social event in which guests and staff work together to plan, prepare, and then eat as a group. This activity developed quite by happenstance, but has proved to be one of the most highly regarded aspects of the respite experience.

Guests understand they are only allowed to stay for only ten days, so within a day so conversations with staff naturally turn to exploring the nature of the issues that brought them to the Center and developing strategies for managing their lives when returning home.

[5] http://www.intentionalpeersupport.org/wp-content/uploads/2014/02/Peer-Support-What-Makes-It-Unique.pdf
[6] https://www.power2u.org/downloads/OpenDialogueApproach.pdf
[7] http://www.communityaccess.org/what-we-do/respite-center

Having the opportunity for extended conversations with staff—who have been trained to carefully listen and respond with honesty—is a surprisingly powerful approach, in that the guest's perspective is being acknowledged and not judged as being right or wrong. Another important way the respite stay is different from a hospital is what happens after discharge. Guests are welcomed to return to the Center for meals, events, groups, and as volunteers. Some guests have been inspired to seek employment.

Also, follow-up supports using Need Adapted Treatment (a form of family psychotherapy), is used to engage family members and the guest in an ongoing dialogue around difficult issues that may have contributed to the crisis. Specially trained mobile teams under the direction of the Visiting Nurse Service provide this support.

The Support Line

A peer-operated support line is considered an essential component in a comprehensive psychiatric crisis response system.[8] The benefits of a support or "warm" line, as opposed to a crisis line, include establishing relationships, active listening, and making sure callers are safe for the night. New York City's crisis line, LIFENET, is responsible to responding to suicide threats or other calls that require a clinical intervention or referral. A transfer protocol between the two services was established at the outset so calls could be quickly routed to the best location.

The support line began operation about a month after the respite center opened and is staffed by the same team of respite workers. Two additional staff are dedicated to the call-in lines from 4 P.M. to 12 A.M., usually for no more than two hours at a time. This staffing arrangement reduces fatigue that crisis line workers often experience.

Since the line began operation, we have received 6,000 unique calls. Many users call more than once, sometimes every day. For some elderly or extremely isolated individuals, our staff might be the only human they speak to all day. Unless there is a queue, staff can stay on a call for as long as someone wants to talk, which is not possible on a crisis line.

Peer Training and Certified Peer Specialists

The third area of responsibility for Community Access under the Parachute project was to assist in the expansion of the peer workforce. As described above, Community Access offers a comprehensive, year-long training and employment program for people with a mental health diagnosis. Given time and resource constraints, we decided to offer an abbreviated training program that would prepare people to become certified peer specialists.

Earlier this year (2015) New York State launched the Academy of Peer Services (APS),[9] an on-line peer training platform with thirteen modules. Peers who pass all the modules are granted a conditional peer specialist certificate and after completing 2,000 hours of work in the role of a peer specialist (equivalent to one year of full-time work), the peer becomes fully certified.

[8] www.tacinc.org/media/13106/Crisis%20Manual.pdf
[9] www.academyofpeerservices.org/

Knowing the many barriers peers face with on-line learning, such as access to technology and literacy issues, we decided to create an APS prep class[10]. Students in the class are given a Chrome netbook and training to access the Internet, set up an account on the APS website, and explore social media in general. Use of the netbooks to access the learning modules is supplemented with standard classroom training that draws from our more comprehensive peer training program. In this way, the concepts and theory behind the skills training are discussed as a group under the guidance of an expert teacher.

The first prep class was launched in April 2015 and the second class began on June 8 and is scheduled to run for 6 weeks, with three evening sessions per week.

Community Access Today

As described above, Community Access has grown substantially over the years, but has strived to main a set of core values that support the rights and dignity of the people we serve. Through our affirmative hiring practice about 1/3 of our 450 staff identify as peers, including program directors and senior managers. This culture of inclusiveness has led to the creation of unique and cost-effective programs that will serve the community and taxpayers well as the system transforms into one that is focused on outcomes and pay-for-performance contracting with managed care companies.

Taken together our work is focused on three key areas:

Housing: We expect to double our housing stock to over 2,000 units within the next five years. Future development will continue to embrace an integrated model with a 50/50 mix of affordable units for families and for formerly homeless people with special needs.

Crisis Supports: Under New York's Medicaid reform effort, we expect to see expanded funding for the development of crisis services. Through an agreement between the State and the Centers for Medicare and Medicaid Services, New York has pledged, in exchange for billions in seed capital, to reduce hospital usage by 25% over the next five years[11]. This can only be accomplished by creating a broad array of preventive and alternative to hospital services, such as mobile crisis teams, support lines, and respite cents.

Peers in the Workforce: Integral to the system transformation described above, is the role of the peer worker. For high-cost Medicaid users, who are often socially isolated and the least likely to follow a defined treatment plan, the peer worker is often the most valuable resource. Engaging people where they live, maintaining an ongoing relationship, and providing practical support and guidance (such assisting with housing and benefits) are all the hallmarks of a skilled and trained peer specialist.

Community Access, through the use of new Medicaid-funded Home and Community Based

[10] Prep class application included as attachment to this testimony
[11] www.health.ny.gov/health_care/medicaid/redesign/

Services[12], expects to see increased funding for peer training and adoption of affirmative hiring policies by other provider agencies, especially as managed care contracts require peers to have a significant role in the service delivery system. Optum's impressive results in transforming the crisis system of care in Tacoma, WA is a great example of this trend[13].

Finally, giving service recipients the opportunity to purchase services through programs known as Self-Directed Care[14] can lead to transformative shifts, as we have seen in the Netherlands, where the Howie the Harp program is being replicated on a large scale through tuition paid by peers to acquire these skills[15].

[12] www.omh.ny.gov/omhweb/News/2014/hcbs-manual.pdf
[13] www.optum.com/content/dam/optum/resources/whitePapers/BSPUB0119S003JV_PierceCty-WR.pdf
[14] www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Self-Directed-Services.html
[15] www.howietheharp.nl/

Comments on H.R. 2646: "A Bill to make available needed psychiatric, psychological, and supportive services for individuals with mental illness and families in mental health crisis, and for other purposes."

Section 103. Reports

A. Peer-Specialist Programs Training and Certification

Comment: We are wholeheartedly endorse this initiative!

B. State of the States Mental Health and Substance Use Treatment

Comment:

The term "emergency room boarding" is used several times in H.R.2646 to describe the situation of people in a mental health crisis waiting in ERs until an inpatient bed is available. The implication seems to be that there are not an adequate number of inpatient beds and government should invest resources to expand this service.

We believe the solution for emergency room boarding is not to create more inpatient beds, but to expand the array of crisis services so that people can avoid going to the emergency room in the first place. A fully functioning crisis response system would include several elements, all of which exist today, but rarely all in the same community.

- Mobile crisis response
- 24/7 crisis phone/text services
- 24/7 support line
- 24/7 urgent care centers
- 24/7 Respite
- Low threshold short-term housing
- 911 diversion (first responder crisis intervention training)

Also, even when the same program exists on paper, its effectiveness care vary widely. For example, a mobile crisis team in New York City may respond within 48 hours; in Pierce County, Washington it's less than 48 MINUTES.

While some communities may feel the need for more hospital beds, New York State is going in the opposite direction. In an agreement with the Centers for Medicare & Medicaid Services, hospital usage is planned to decrease by 25% for high-cost, high-need Medicaid users.[16]

[16] www.health.ny.gov/health_care/medicaid/redesign/dsrip/

Section 201. Mental Health Policy Laboratory (NMHPL)

Comment: There is a lack of research or evaluation on the long-term use of psychotropic medications.

Purpose: To evaluate and disseminate to such evidence-based practices and services delivery models using the best available science shown to be cost-effective while enhancing the quality of care furnished to individual

Section 202. Innovation Grants

Comment: The proposed duration period (less than 2 years) seems too short, given that most programs require a start-up period and then additional time to test and adjust new approaches.

Section 203. Demonstration Grants

Comment: Funding is restricted to "evidence-based" programs or projects. An independent and transparent review method should be added so "emerging best-practices" could be included. Many approaches have been documented in peer-reviewed journals, but fall short of the standards required for inclusion as a best practice.

Section 205. Extension of Assisted Outpatient Treatment Grant Program for Individuals with Serious Mental Illness

Comments:

A. Evidenced-Based Practice

The National Registry of Evidenced-Based Practices and Programs[17] lists 94 interventions for mental health treatment recognized as evidence-based practice, including AOT. Of these, there are 52 interventions that promote employment, reduce homelessness, and improve quality of life, including:

The Compeer Model pairs trained volunteers with adults (including veterans and the elderly) and youth (including children with an incarcerated parent), to reduce social isolation and to increase community reintegration.

Critical Time Intervention (CTI) is a time-limited case management model that is designed to support continuity of care and community integration for persons with severe mental illness who are transitioning from institutional settings (e.g., shelters, hospitals, jails) to community care and are at risk of homelessness.

[17] www.nrepp.samhsa.gov

The ICCD (International Center for Clubhouse Development) Clubhouse Model is a day treatment program for rehabilitating adults diagnosed with a mental health problem.

Housing First, a program developed by Pathways to Housing, Inc., is designed to end homelessness and support recovery for individuals who are homeless and have severe psychiatric disabilities and co-occurring substance use disorders.

The Psychiatric Rehabilitation Process Model is a process guiding the interaction between a practitioner and an individual with severe mental illness. Manual driven, the model is a client-centered, strengths-based intervention designed to build clients' positive social relationships, encourage self-determination of goals, connect clients to needed human service supports, and provide direct skills training to maximize independence.

Wellness Recovery Action Plan (WRAP) is an intervention for adults with mental illness. WRAP guides participants through the process of identifying and understanding their personal wellness resources ("wellness tools") and then helps them develop an individualized plan to use these resources on a daily basis to manage their mental illness.

Making the promotion of AOT a priority for government funding purposes, among all the possible evidenced-based approaches, is not supported by research or other logical explanation. Requiring states to adopt AOT as a legal mandate to secure funding for other programs seems inconsistent with other aspects of H.R 2646 that promote research-based solutions and transparent analysis.

B. AOT Models

Research has shown that AOT programs vary greatly, as do the outcomes[18]. In New York City, for instance, an AOT-assigned individual is given priority for supportive housing, which greatly improves community stability. In other places supportive housing barely exists and the "treatment" offered is an intensive case manager who might be working with 50 or 60 other clients. In these cases, support can be little more than a requirement to take medication.

Further, while AOT may have achieved the status of an evidenced-base intervention, the services offered under an individual AOT program itself are often NOT evidence-based. For example, requiring individuals to take psychotropic medications is not on National Registry of Evidenced-Based Practices and Programs. Neither would the requirement to attend a day treatment program or any number of interventions that a state or locale might deem helpful, but have no evidence to support their use.

This lack of standards creates a concern for rights advocates who fear states will adopt AOT legislation to meet the requirements of the law, then "race to the bottom" to deploy a service that ignores the aspirational vision outlined in Section 223 of H.R. 2646, which promotes demonstration programs for Community Behavioral Health Clinics that include:

[18] www.onlinelibrary.wiley.com/doi/10.1037/0002-9432.77.3.350/abstract

- Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization.
- Screening, assessment, and diagnosis, including risk assessment.
- Patient-centered treatment planning or similar processes, including risk assessment and crisis planning.
- Outpatient mental health and substance use services.
- Outpatient clinic primary care screening and monitoring of key health indicators and health risk.
- Targeted case management.
- Psychiatric rehabilitation services.
- Peer support and counselor services and family supports.
- Intensive, community-based mental health care for members of the Armed Forces and veterans

AOT should mean guaranteed access to this array services, and a home.

> "There needs to be an array of services, with case management, integrated mental health and substance abuse, housing, supports. People have to navigate a maze in order to get access to the services they need." Ronald S. Honberg, national director for policy and legal affairs at the National Alliance on Mental Illness.
>
> "We do not believe that AOT is the solution to the problems of the mental health system, to the sad reality that there are so many people who are falling through the cracks," concludes NAMI's Honberg. "On the other hand, as a last resort, we do think it can be helpful with certain individuals."[19]

C. Social Justice

AOT is disproportionately applied to black citizens.[20] This is justified by the fact that blacks are more likely than whites to be in the public mental health system. If we accept this rationale, then it's acknowledged that AOT is a service for primarily low income and minority users of the public health system, i.e., not a service that impacts all citizens equally.

Section 597. Fellowships

Crisis Intervention Grants for Police Officers and First Responders

Comment: We applaud this recommendation. Community Access has been a leader in promoting CIT programs in New York City. Our successful advocacy efforts have led to the launch of New York City's first training program, which began on June 1.

[19] www.behavioral.net/article/aot-cost-effectiveness-study-stirs-national-debate?page=2
[20] http://content.healthaffairs.org/content/28/3/816.full

Section 301. Interagency Serious Mental Illness Coordinating Committee

Comment: We applaud the measures described below, in particular, employment and educational attainment.

Measurement of: (A) reduced rates of suicide, suicide attempts, substance abuse, overdose, overdose deaths, emergency hospitalizations, emergency room boarding, incarceration, crime, arrest, victimization, homelessness, and joblessness; (B) increased rates of employment and enrollment in educational and vocational programs. (p 106)

Section 501. Enhanced Medicaid Coverage

Comment: While we have concerns about loosening the Medicaid Institutions for Mental Diseases (IMD) exclusions, we believe a range of possible interventions need to be explored. Limiting the time a person may be confined to a facility seems to be a much more critical factor in preventing institutional care than the total numbers of beds in that same facility.

Inpatient psychiatric care: short-term, acute inpatient psychiatric hospital care means care that is provided in either an acute-care psychiatric unit with an average annual length of stay of fewer than 30 days that is operated within a psychiatric hospital operated by a State; or a psychiatric hospital with an average annual length of stay of fewer than 30 days. (p 126)

Section 233. Demonstration Programs to Improve Community Mental Health Services

Comment: We enthusiastically support the study and expansion of programs that promote health, recovery, and community integration.

Mr. PITTS. The chair thanks the gentleman.

I now recognize Ms. Billingsley 5 minutes for an opening statement.

STATEMENT OF MARY JEAN BILLINGSLEY

Ms. BILLINGSLEY. Good morning, Chairman Pitts, Ranking Member Green. Thank you for the opportunity to testify today on this important topic that has touched me and my family personally.

My name is Mary Jean Billingsley. I have a Master's Degree in Counseling and Personnel Services, but more importantly, I am the mother and co-guardian of Tim Costello. Tim is 22 years old and is dually diagnosed with both significant mental illness and developmental disabilities. Tim lives in Johnson County, Kansas. We are one of the families with a positive outcome that would not have been possible if the Helping Families in Mental Health Crisis Act of 2015 was law when my son encountered his problems. Several provisions of this legislation would have had a detrimental impact on the work of the Protection and Advocacy for Individuals with Mental Illness, the PAIMI program, in addressing Tim's needs. The changes to the PAIMI program in this bill would not help families, but would, in fact, harm families like ours.

Tim's mental illness manifests itself with certain behaviors. Because of these behaviors, Tim was placed in a psychiatric institution in 2010. He was 17 at the time. In the summer of 2011, Tim was going to be discharged with no plan, and without proper supports in place. Without those supports, Tim's discharge was doomed to fail. We were devastated. Because Tim has both significant mental illness and a developmental disability, the different providers were trying to pawn Tim off to each other. Tim was always somebody else's problem. Without the right supports, Tim was going to continue to cycle in and out of institutions, at a high cost to both taxpayers and Tim's ability to recover.

Tim wanted to live in the community. Our family wanted Tim to live in the community. This is a right granted under the Americans With Disabilities Act, allowing him to get needed treatment in the community instead of at an expensive psychiatric institution. We contacted the Disability Rights Center of Kansas, the federally mandated protection advocacy agency for people with disabilities, which operates the PAIMI program. Because of the PAIMI program, DRC was able to help Tim and my family with his complex situation. Sorry, I missed a page, excuse me.

Every brick wall the system threw up against us, the PAIMI program gave DRC the authority to tear it down. Kansas policy made it impossible for young adults like Tim to transfer out of psychiatric institutions to community long-term care programs with needed supports. DRC was able to negotiate a change in this policy, allowing Tim to obtain services through the Money Follows the Person Program, and obtain the long-needed supports in order to live successfully in the community.

This bill would prohibit PAIMI-funded programs from engaging in much-needed policy work, even using nonfederal dollars. Tim's civil and human rights under the ADA would not have been protected.

Tim was living successfully in the community, and we thought our problems were over, but they were only beginning. Tim then faced discrimination simply because of his disability. Some local governments in Johnson County, Kansas, started using zoning and land use ordinances to attempt to close Tim's community group home, as well as others. A not-in-my-back-yard attitude prevailed, targeted against Tim and others, because some did not want those people living in their neighborhood. We, again, contacted DRC for help. After failed attempts to work with local governments, Tim and 16 similar individuals with disabilities urged DRC to file disability discrimination complaints with Housing and Urban Development, alleging violations of federal and state laws. The HUD case is currently pending.

If this bill were law, the PAIMI program would have been prohibited from helping our son with legal advocacy in the housing discrimination case because it is not abuse and neglect. The current PAIMI law has no such limitation. Without the help of DRC and the PAIMI program, Tim would still be cycling in and out of institutions. The resolution of Tim's current discrimination case may require DRC to seek a change in policy through legislation or local ordinances, which they currently can do using nonfederal funds. H.R. 2646 will prohibit this, and severely limit the remedies available for Tim.

Tim's case was complicated. The PAIMI program gave DRC the ability to engage in every aspect of protecting Tim's rights, including the flexibility to use nonfederal dollars to engage in needed policy change. Tim's prior institutionalization and current housing discrimination involves numerous disability rights issues, including unjust denial of Medicaid services, violation of rights under the ADA and housing discrimination. Often the issues faced by people with mental illness are not abuse and neglect, but the problem of human and civil rights.

In closing, this bill would limit the authority of the PAIMI program to cases of abuse and neglect, making it far easy to discriminate against and violate the rights of people with mental illness. It would also eliminate advocacy for policy changes, even with nonfederal dollars, on behalf of persons with disabilities, including mental illness. Those provisions are bad for families and bad for my son, Tim.

Thank you for the opportunity to testify.

[The prepared statement of Ms. Billingsley follows:]

Statement of Mary Jean Billingsley before

The House Energy and Commerce Committee Health Subcommittee

for a hearing entitled "Examining H.R. 2646, the Helping Families in Mental Health Crisis Act."

June 16, 2015 10:00 am

Good morning Chairman Pitts, Ranking Member Green. Thank you for the opportunity to testify today on this important topic that has touched me and my family personally.

My name is Mary Jean Billingsley. I have earned a Master's Degree in Counseling and Personnel Services. More importantly, I am the mother and co-guardian of Tim Costello. My son Tim is 22 years old and is dually diagnosed with both significant mental illness and developmental disabilities. Tim lives in Johnson County, Kansas.

We are one of the "families" with a positive outcome that would not have been possible if the "Helping Families in Mental Health Crisis Act of 2015" was law when my son encountered his situation. Several provisions of this legislation would have a detrimental impact on the work of the Protection and Advocacy for Individuals with Mental Illness (PAIMI) program in addressing Tim's needs. The changes to the PAIMI program in this bill would not help families. Those changes, in fact, would harm families. I fear if this bill had been law, the challenges we faced in helping our son Tim would have been insurmountable.

Tim's mental illness manifests itself with certain behaviors. Because of these behaviors, Tim was placed at Lake Mary, a psychiatric institution for youth under the age of 21, in 2010. In the

summer of 2011, Tim was going to be discharged with no plan and without proper supports in place. Without these supports Tim's discharge was doomed to fail. We were devastated.

Because Tim has both significant mental illness and a developmental disability, it felt like the different providers were trying to pawn Tim off on each other. Tim was always someone else's "problem." Without the right supports, Tim was going to continue to cycle in and out of institutions, at a high cost to both taxpayers and Tim's ability to recover. Tim wanted to live in the community. Our family wanted Tim to live in the community. This is a right granted under the Americans with Disabilities Act (ADA), allowing him to get needed treatment in the community instead of at an expensive psychiatric institution.

We contacted the Disability Rights Center of Kansas (DRC), the federally mandated Protection and Advocacy agency for people with disabilities, which operates the PAIMI program. Because of the PAIMI program, DRC and their staff has the knowledge and authority to engage in all kinds of advocacy for people with disabilities. Because of the PAIMI program, DRC was able to help me and my family with this complex and multi-faceted situation.

Every brick wall the system threw up against us, the PAIMI program gave DRC the knowledge and authority to work to tear it down. Kansas policy made it impossible for young adults like Tim to transfer out of psychiatric institutions to community long-term-care programs with needed supports. DRC staff were able to negotiate a change in this Kansas agency policy allowing Tim's stay at the psychiatric institution to be characterized as a nursing home stay in order to allow Tim to obtain services through the Money Follows the Person (MFP) program. MFP allowed Tim to obtain the needed long-term supports in order to live successfully in the community.

The PAIMI program gave DRC and their staff the knowledge and ability to advocate changing Kansas policy creating unnecessary and expensive institutionalization that was contrary to the ADA. This bill would prohibit PAIMI-funded programs engaging in this much needed systemic and legislative policy work, even with non-federal dollars. DRC's ability to advocate for public policy change with non-federal dollars ensured Tim's civil and human rights under the ADA were protected.

Everything was finally working for Tim and allowing him to live successfully in the community. We thought our problems were over. We found out they were only beginning. Tim then faced discrimination simply because of his disability. Some local governments in Johnson County, Kansas started using zoning and land use ordinances to attempt to close Tim's community group home as well as others. A "Not in My Backyard" attitude prevailed – targeted against Tim and others because some did not want "those people" living in their neighborhood. We again contacted DRC for assistance to counter this housing discrimination.

After failed attempts to proactively work with the local governments, Tim and 16 other similarly situated individuals with disabilities engaged DRC to file disability discrimination complaints with the United States Department of Housing and Urban Development (HUD). The complaints alleged violations of the Fair Housing Act and Kansas law. These discriminatory local policies were attempting to deny persons with disabilities the opportunity to live in communities the same way people without disabilities are allowed. The HUD case is currently pending. If this bill were law, the PAIMI program would have been prohibited from helping our son with legal advocacy in this housing discrimination case because it is not "abuse or neglect." Thankfully, the current PAIMI law has no such limitation.

Without the help of DRC and the PAIMI program, Tim would still be cycling in and out of institutions. Based on my understanding, the resolution of Tim's current housing discrimination case may require DRC to seek a change in policy through legislation or a local ordinance, which they currently can do using non-federal funds. H.R. 2646 would prohibit the PAIMI program from engaging in this type of public policy advocacy, even with non-federal dollars. This severely limits the remedies available to people like my son, Tim.

Often the issues faced by people with mental illness are not abuse and neglect, but the protection of civil and human rights. Tim's case, like those of so many people with disabilities, was multifaceted and complicated. Thankfully the PAIMI program gave DRC staff the ability and knowledge to engage in every aspect of protecting Tim's rights. The PAIMI program must also have the flexibility to allow those agencies to use non-federal dollars in order to engage in legislative or local government public policy advocacy to be completely effective.

Tim's prior institutionalization and current housing discrimination involves numerous disability rights issues including unjust denial of Medicaid services, violation of rights under the ADA, and housing discrimination. His situation also required advocacy to force the mental health and developmental disability systems to put their turf battles aside and serve Tim.

The complicated and interconnected nature of these issues requires the PAIMI program give Protection and Advocacy agencies the authority to engage in all disability rights issues, not just "abuse and neglect." Without the PAIMI program, Tim's rights would not be protected.

In closing, this bill would limit the authority of the PAIMI program to cases of "abuse and neglect," making it far easier to discriminate against and violate the rights of people with mental illness. It would also eliminate advocacy for public policy changes even with non-federal dollars on behalf of Americans with a disability, including mental illness. Those provisions are bad for families and bad for Americans with mental illness, like my son Tim.

Thank you for this opportunity to testify. I look forward to any questions you may have.

Mr. PITTS. The chair thanks the gentlelady, and now recognizes Mr. Rosenthal 5 minutes for his opening statement.

STATEMENT OF HARVEY ROSENTHAL

Mr. ROSENTHAL. Good morning, and thank you for this extraordinary opportunity to testify today.

I am Harvey Rosenthal——

Mr. PITTS. Is your mike on?

Mr. ROSENTHAL. Yes.

Mr. PITTS. Yes, go ahead.

Mr. ROSENTHAL. Thank you. Sorry about that. A person in 43 years of recovery from a bipolar disorder, with 40 years of experience working in the field, 18 in a hospital, clinic and rehab program, with 22 working as an advocate who has come to sit on New York's Medicaid Redesign Team, its Behavioral Health Workgroup, and our Most Integrated Setting Council.

Thank you for including a recovering person here. I urge you to include more of us in these deliberations.

My experience has told me that the best way to fix a broken system isn't by forcing people into the exact same services that have failed them in the past. It won't be achieved by reducing privacy protections, limiting access to personal and systemic advocacy, or by all of a sudden moving sharply to a medical biological bent in ways that could undo or jeopardize the extraordinary gains of the recovery and consumer-focused approaches that have taken us decades to develop.

We are not working on my comments. They will tell you, in my written comments, they will explain my position.

I woke up this morning and I felt like I had to use and focus on a word that has barely been discussed today, and that is recovery.

And so as I said before, recovery, rehabilitation, consumer, and peer support movements have changed the face of service delivery to people with the most serious mental health conditions in this country and around the world. Before these movements took hold, our system told people they would never get well, never have intimate relationships, never get a job, and never be able to make most of their most personal decisions. I know because I saw it every day when I worked in the state hospital. We told people that they would never get a job, that they would be poor, idle, isolated, and segregated from society. They would be permanently disabled. The primary treatments of the day were medication and hospitalization. And I know we are talking a lot about that here in the bill, but we are not talking enough about recovery. We are talking a lot about meds and beds, but not enough about recovery.

Our movements brought hope to people and their families, many for the first time. Hope was, and it is still not enough, a part of our toolkit. Even the sickest person can improve and get well. Although they are dissuaded from going to services if the service message is that you are sick, that you need to take medication, that you can't make decisions, that you will face coercion, that your privacy rights will be violated. It is not a way to engage people.

I will tell you a way to engage people. We run a peer bridging program in the streets of New York City. We work with the hardest to serve; people that are very sick, and don't have good housing,

who have addiction and trauma, and are, by definition, hard to find, victims of abuse, veterans. These are our greatest challenges. We developed a model of peer bridging that hits the streets. Too much of our system stays in the office and blames the patient. We hit the streets, and we go again and again and again to engage people. We work with families. We have helped hundreds of people in the city, reduce their relapses and their readmissions by 50 percent. Yet these services have not reached the standard of evidence-based practice. We are talking about research on brains. We have to also do research on peer services and recovery services because otherwise, we will undo them.

When we talk about AOT, we are typically mandating people to take medicine in a hospital. When we talk about limiting what PNAs do, we are fearing that people will get off medications. When we are talking about the IMD exclusion, we are talking about more beds. We have come a long way to just talk about medications and beds.

And, you know, when we talk about importing all of SAMHSA into the office of a new Assistant Secretary, we are gambling on the possibility that all of the work that has been done to transform and offer hope, recovery, wellness, employment, community integration, person-centered and self-directed care, might get lot in a large bureaucracy.

There are some out here that believe the recovery movement is the enemy; that we are not interested in working with the sickest individuals. But I can tell you that we have helped tens of thousands of people stay out of jails and prisons and homeless shelters, and avoid suicide. We must absolutely be able to really focus in funding these programs. So we greatly need to offer the promise of recovery to people. You will see in my comments that we support a number of the things that Chairman Murphy—we laud him for his passion, but we really need to see a full range of recovery services, like Steve has talked about. There is not enough focus here in the bill, and it has to be said.

Thank you.

[The prepared statement of Mr. Rosenthal follows:]

New York Association of Psychiatric Rehabilitation Services, Inc.

Harvey Rosenthal
Executive Director
harveyr@nyaprs.org

United States House of Representatives
Committee on Energy and Commerce
Subcommittee on Health

"Examining H.R. 2646, the Helping Families in Mental Health Crisis Act."

June 16, 2015

Testimony of Harvey Rosenthal
Executive Director
New York Association of Psychiatric Rehabilitation Services

194 Washington Avenue • Albany, NY 12210 • Phone: (518) 436-0008 • Fax: (518) 436-0044 •
www.nyaprs.org

Good morning. Thanks so much for this opportunity to speak before you on issues of such critical importance to people with serious mental illnesses across our nation. I'm Harvey Rosenthal and I have served for the past 23 years as executive director of the New York Association of Psychiatric Rehabilitation Services (NYAPRS), a New York based coalition of recovering people and community providers who have been dedicated to improving services, social conditions and public policies to help people with serious mental health conditions to advance their recovery, rehabilitation, rights and full community inclusion.

I am also heavily involved in state mental health and healthcare policy, currently serving on New York's Medicaid Redesign Team, the Behavioral Health Work Group and our Most Integrated Setting Coordinating Council.

All of my 40 years of experience in the public mental health system as both a provider and an advocate has been aimed at supporting the needs of people with the most serious mental health conditions, partly because this is very personal to me as I am in long term recovery from a bipolar condition.

I want to thank the committee for inviting a person in recovery to testify today and I urge you to reach out to and include more input from the ultimate stakeholders, people with psychiatric disabilities.

My experience tells me that best way to fix a broken system isn't by forcing people into the exact same services that failed them in the past. It won't be achieved by reducing

privacy protections, limiting access to personal and systemic advocacy or by fostering a sharp swing to a more medical, biological bent in ways that could undo the extraordinary impact of the recovery and consumer focused approaches that have taken us decades to develop and proliferate.

While some have claimed that these recovery and rehabilitation services have abandoned the most seriously disabled and distressed, what is instead true is that tens of millions of Americans would be on the street, in prison or at risk for suicide, were it not for these services, most of which are relatively new and haven't been afforded yet the research to deem them as evidence based practices.

The focus on evidence based practices is essential but, unless this measure devotes substantive research funding to evaluate whether an entire new generation of recovery focused innovations meet those standards, they will be lost.

I'd like to share concerns we have about several provisions of this measure.

Assisted Outpatient Commitment: NYAPRS is joined by countless colleague groups in our state and nationally in our strong opposition to court mandated outpatient treatment.

Two major AOT studies have been conducted in New York comparing court mandated and voluntary approaches. A 1999 Bellevue study concluded that more and better

services made the difference, irrespective of whether individuals had court mandates.[1] A 2009 Duke University study ordered by the NYS legislature conceded that is was unable to compare the outcomes from roughly 8,000 court orders and 7,000 voluntary 'enhanced service packages,' adding that "it is difficult to assess whether the court order was a key ingredient in promoting engagement or whether comparable gains in engagement would have occurred over time with voluntary treatment alone."[2]

Why aren't we finding as much money to evaluate and expand voluntary outreach, engagement and rehabilitative approaches as we are in dedicating $20 million for state or local AOT demonstration program expansions and in offering states that have or add AOT laws a 2% increase in their federal block grant allocations?

If I am interpreting the bill correctly, it will link block grant dollars with a demonstration that states have in effect active programs that while they may include AOT they may just as equally include a broad array of these voluntary approaches, to engage people with serious mental illnesses in comprehensive services. If this is so, we are very supportive of this approach.

Lifting the IMD Exclusion: States should use broad new Medicaid flexibility to quickly ramp up preventive, crisis and recovery community based alternatives instead of asking federal taxpayers to spending billions to bring federal share of Medicaid into state and private psychiatric hospitals.

---

[1] 2001 "Assessing the New York City Involuntary Outpatient Commitment Pilot Program" Steadman et al Psychiatric Services

[2] New York State Assisted Outpatient Treatment Program Evaluation June 30, 2009

Too often, the problem may not lie in a lack of beds but the lack of information about where open beds can be found. That's why we support the creation of real-time Internet-based acute psychiatric bed registries that identify available acute beds in public and private inpatient psychiatric facilities and public and private crisis stabilization units.

We are concerned that H.R. 2646 does not require full maintenance of efforts and reinvestment of savings to bolster our community systems of care, and that a study to track how savings were used won't take place until 2 years after this initiative is implemented. By then, tens of millions of dollars would have left cash poor state mental health service systems to be transferred to state general funds for other purposes entirely.

Protection and Advocacy for Individuals with Mental Illness: While we appreciate the Congressman has left PAIMI funding intact in this proposal, H.R. 2646 would eliminate critical functions that have made huge differences in the lives of people with psychiatric disabilities.

Under this proposal, P&As could no longer help the vet who is facing employment discrimination, the child who is being denied educational services or the individual who faces housing discrimination. And they could no longer protect individuals who are the victims of financial exploitation, abuse, and neglect by errant family members or guardians.

HIPAA: We very much share family members' outrage and heartbreak when community providers are unwilling to either listen to or share information about their loved one's status and greatly appreciate Congressman Murphy's prioritization of this issue.

All too often, this happens because providers don't understand the latitude and obligation they have under existing guidance, but sometimes providers simply hide behind HIPAA to avoid sharing an appropriate level of information.

We recommend codifying the recent guidance by the Federal Office of Civil Rights into law and conducting an aggressive stakeholder education program, as proposed by Congresswoman Matsui, with several inclusions:

- Individuals should be given **advanced notice** of the desire to share their information with family members or other caregivers and include an explanation of what information is to be shared and why it is clinically desirable to share such information.
- The use of **Psychiatric Advance Directives**, which are tools for designating in advance an individual's preferences concerning recipients of protected health or mental health information, should be promoted.
- H.R. 2646's provisions that sharing patient information may not include "friends' or those with documented histories of abuse be included in any final agreement.

.

SAMHSA has played a groundbreaking role in helping to promote the development of our entire field over the past two decades. It has helped fund and promote many of our most important innovations, including the concepts of recovery, rehabilitation, wellness, community integration, peer support and person centered and self-directed care. In recent years, SAMHSA has been accused of paying insufficient attention to the most needy. If so, the Health and Human Services Administration can increase its oversight role and report to Congress of necessary improvements in this area.

Peer Support: While we very much appreciate H.R. 2646's highlighting of peer support and its interest in conducting a survey and report of nationwide peer support programs, it would be inappropriate for Congress to then move to define these standards. We are not aware that it takes this level of involvement for the other disciplines. Congress should defer to CMS and state and national credentialing bodies to set such standards.

At the same time, I'd like to thank and congratulate Congressman Murphy for all that you have done over the past 3 years to put mental health issues on the front burner in Congress and across the nation.

H.R.2646 contains a number of critically important initiatives to help us sharpen, extend and make more effective and accountable the help we offer to them that include:

- mandating stronger federal oversight over enforcement of behavioral health care parity, which became law in New York State a decade ago thanks to the relentless persistence of then Assemblyman Paul Tonko.

- extending incentive payments to help behavioral health agencies to prepare for and to implement the use of electronic healthcare records
- raising the focus on the integration of primary and behavioral health care services and improved coordination between mental health and criminal justice systems
- bolstering of standards and guidelines for hospital discharge planning and follow up
- continued or new funding for numerous suicide prevention initiatives
- expanding first episode psychosis programs like RAISE
- the creation of an Interagency Serious Mental Illness Coordinating Committee we believe should include SAMHSA and the Centers for Medicare and Medicaid Services, which funds the vast majority of the nation's mental health programs

We also greatly appreciate the $55 million allocation for specialized mental health education for law enforcement, corrections officers, paramedics and other first responders.

Thanks once again for this opportunity to speak before you today.

Mr. PITTS. The chair thanks the gentleman. Thanks to all of our witnesses. That concludes the opening statements of our witnesses.

We will now begin questioning, and I will recognize myself 5 minutes for that purpose.

Dr. Lieberman, we will start with you. Do you believe that the community mental health system, developed in the 1960s, was designed to serve the needs of individuals who experienced the most chronic and severe manifestations of mental illness, and if not, what are the consequences of this?

Dr. LIEBERMAN. Mr. Chairman, it may have been designed with that intent, but it was really woefully naive and ill-conceived and it failed miserably. I mean the idea was to humanize mental health care by being able to move patients from institutions into the community, and have them receive an array of support services, including housing, including case management, including medication and rehabilitation, but none of that was there, and they simply fell through the cracks. And we have never sort of regained traction on that program and that population since.

Mr. PITTS. Mr. Gionfriddo, how has the deinstitutionalization of the mentally ill worked out over the past ½ century? In your experience, why do so many mentally ill individuals pass through our criminal justice system or end up homeless, and are these individuals getting treatment while in prison or living on the streets?

Mr. GIONFRIDDO. Those of us who were policymakers in the 1970s and '80s really didn't understand two things about our system. One was that we were going to have to put front and center the kind of clinical services and support services that people would need when they were not in institutions. The second was we didn't understand that the pipeline was a pipeline of children, that these were illnesses that primarily affect initially children and young adults. And so as a result of that, what we have ended up doing with deinstitutionalization, the kind that we did in the '70s and '80s, was a reinstitutionalization of people into prisons. And those prisons and jails are not at all connected with the rest of the system, and that is a real tragedy.

Mr. PITTS. Mr. Kennedy, at the present time, how does the IMD exclusion impact on the availability of clinically effective inpatient treatment options, particularly for Medicaid enrollees? How, if at all, would Title V of H.R. 2646 go about fixing that?

Mr. KENNEDY OF MASSACHUSETTS. Well, first of all, we have to understand that if we are going to treat these illnesses like all other illnesses, if the illness is critical and needs intensive inpatient treatment, you wouldn't limit that if it were the cancer patient, you wouldn't limit that if it was the cardiovascular patient, and you shouldn't limit that simply because the patient is someone with a psychiatric disorder.

So I understand the derivation of this IMD exclusion. It came out of the days when people were warehoused, where care was substandard and horrifying, and yet we took a polar opposite approach by just not paying for any inpatient treatment as a result. Now we have progressed 5 decades, and we are stuck in the same mentality as 5 decades ago? No. We should follow the science, treat these illnesses as real illness, and in doing so, treat them if they need to

be treated in inpatient settings, do so, and not preclude that as an option.

Mr. PITTS. Senator Deeds, why is it important that we have enough hospital beds for the most seriously mentally ill who need hospitalization? Isn't a large part of the problem not just the lack of sufficient inpatient beds, but also the absence of any systematic way for the states to determine in a timely fashion where a vacant bed may be located?

Mr. DEEDS. That is a really good question. The reality is that when we moved to a community-based system, we reduced dramatically the number of beds we have all over the country. It is not just a national problem, it is not just a Virginia problem, it is everywhere in the country. And, as Representative Kennedy said, when a person has a heart attack, they are not turned away from an emergency room because the emergency room is full. It is just like when a person commits murder, they are not turned away from a jail because a jail is full. When a person has a mental health crisis, we have to find a bed.

And in my view, hopefully, the larger number of people who need to be treated can be treated in the community, and we are not going to have to put them in an institution. But also in my view, we—and at this time, we have a shortage of beds nationally for those who have long-term mental health issues that need some period of institutionalization, sometimes 30 days or more. We don't have the capacity in Virginia to provide that service to people.

Mr. PITTS. Dr. Lieberman, you wanted to add something?

Dr. LIEBERMAN. If I could add something, Mr. Chairman. This is an egregious problem that is complicated but understandable. What happened was that the inpatient length of stay for most individuals with psychiatric illness in the 1960s and '70s was months, if not years. And they were either in state mental institutions, or they may have been receiving long-term psychotherapeutic treatment in the kind of euphemistically named institutions out in rural areas—typified by what the Menninger Clinic was. And when payers and the government found out the conditions in hospitals were terrible, and people weren't getting better and discharged, and psychotherapy and psychoanalytical treatment wasn't doing anything either for serious mental illness, they said, we are not going to pay for this stuff.

The government health insured—Washington, D.C., when I went to medical school in the 1970s, had the highest concentration per capita of psychiatrists of any city in the country. Do you know why? Because GHI paid for psychoanalysis. That stopped pretty quick when there was no evidence to support it, and people started getting concerns of health care costs.

So the kneejerk reaction was to go the other way and to limit length of stay, which plummeted down to now the single digit days as average length of stay.

In my hospital, New York Presbyterian Hospital, the largest health provider in the New York metropolitan area, the average length of stay range—I mean the occupancy rate in the hospital in medical surgical services ranges from maybe 60 percent to 85 percent, and in the psychiatry units it is 100 percent always, and the psych ED is the same thing. But the hospital, which is struggling

for financial viability, will never give me another bed because it is not financially desirable to do so. And so we are caught in this quandary. As Senator Deeds said, if we had an effective mental health care system which could deter people coming into it by preventive care, which provided adequate ambulatory care to keep people from having to come into the hospital, we would decompress this, but it will take time.

Mr. PITTS. The chair thanks the gentleman.

My time has expired. The chair recognizes the ranking member, Mr. Green, 5 minutes for questions.

Mr. GREEN. Thank you, Mr. Chairman. I want to thank all our panel.

My experience outside of being a legislator is as a lawyer doing probate work in the 1980s in Houston, Harris County. I was so proud when we got a Harris County psychiatric center, managed by the University of Texas Health Science Center. But we have fewer beds there today than we did in 1988, and that is the frustration I think seen around the country.

But when I was practicing law, I was so happy when I found somebody who actually was a veteran because I could get them into our veterans hospital that had real treatment, and we didn't have to wait for a bed. And that is our problem, and I know it is even worse today because of the growth in our population.

My frustration back then was that very few insurance policies covered mental health. And I know the Affordable Care Act did much to advance mental health care largely by extending coverage for mental health and substance use disorders. It required new and small group insurance plans to cover these services as essential health benefits. In addition to advancing parity of coverage, the ACA authorized the Center for Medicare and Medicaid Innovation, the CMMIs, to test innovative models of care. The first round of health care innovation grants CMMI—10 were focused specifically on mental health.

Mr. Coe, in your testimony you described the work Community Access has done to create programs that provide innovation and tailored services to people experiencing psychiatric episodes. I understand Community Access received the Health Care Innovation Grant from CMS to create Parachute NYC, or New York City.

Mr. COE. Right. Thank you, Congressman. That is correct. Community Access, in partnership with the City of New York, applied for a grant to create alternatives to hospital care, and the city called it Parachute NYC. It means a soft landing for people in a psychiatric crisis. Then the Parachute Program—it actually created four residences: one in Staten Island got left out again, but one in each borough, as well as enhancing the workforce by adding peers to mobile crisis teams, and creating a peer-run support line. So our residence opened first in January of 2013, so we have run it just for about 2 years.

We had almost no guests for the first 6 months. We had five, six guests. We had a capacity for seven. We had over 100 people in the last 5 months. And 25 percent of those were self-referrals. So if you put a service out that is an experience that people appreciate, they will flock to it. People can come and go. People are encouraged to talk to staff. Our staff are all peers. We had 800 applicants for 14

positions. And then training people on how to talk and listen to people, and brought in evidence-based practice to do that.

New York has made a deal with the Center for Medicaid and the Government to reduce actually the usage of hospital use by 25 percent over the next 5 years, including Dr. Lieberman's hospital, which is part of the reform plan, by creating more respite services, mobile crisis teams. Our mobile crisis teams take 48 hours to go out. In Pierce County, Washington, they take 48 minutes to go out. And a family in crisis needs a response, it needs a place to call, and then they need somebody to respond when the call is made.

So Parachute NYC was a package of improving mobile crisis, offering alternatives to hospitalization, offering support lines, and expanding the peer workforce.

Mr. GREEN. Mr. Coe, do you think that program could be replicated around the country, although I know we have a lot of programs all over the country that actually may not be Federal Government funding, but actually coming from the community?

Mr. COE. It is a simple model. I think that the idea—and I think the resistance that we faced initially was that it wasn't going to be safe, that peers are going to be running it, therefore, it is not going to be a safe place for people to go. So we had open houses, we had cake sales, we had people come and meet the staff. The staff went out and did presentations to agencies so they could see who worked there. We also linked to medical facilities and health care. So we don't ignore that safety is first. So you take care of people when they come in the door, if you notice a problem, you can seek help, but it has to be a system, and it can't be just one thing. It has to be organized, system-wide. And there are very few places around the country where they have done that.

The crisis intervention teams, and a lot of—Arlington, Virginia, has a great program. Mental health, police, drop-off centers. Very well organized, they meet monthly. That is the kind of comprehensive——

Mr. GREEN. OK.

Mr. COE [continuing]. Service that you can put together. So, yes.

Mr. GREEN. Thank you, Mr. Chairman. I know I am out of time. But, Ms. Billingsley, I wanted to ask you a question. I will submit it and we will get a response about the success with your job. So thank you.

Mr. PITTS. The chair thanks the gentleman.

Now recognize the vice chairman of the full committee, Mrs. Blackburn, 5 minutes for questions.

Mrs. BLACKBURN. Thank you, Mr. Chairman. And thank you to each of you.

I am going to come to Senator Deeds and Rep. Kennedy and Mr. Rosenthal. As I said, we have worked on this. Chairman Murphy has done such a tremendous job on this, and we want to have a piece of legislation that we can put in place, get signed into law, and then have that foundation that will work us toward parity.

With that in mind, what I would like for the three of you that I have mentioned, and, Senator Deeds, let's start with you, to just talk to me, give me the two or three things that you think are best about the bill that will be most helpful, and then the couple of things that probably you think we need to go back to the drawing

board on. And very quickly to the three of you, and then the others of our esteemed panelists, I would like for you to just submit that to us in writing.

I think as we drill down, and as we get something ready to move forward, give me your thoughts. This is helpful to us as we plan forward.

Mr. DEEDS. And honestly, I was provided a summary of the bill, and that is what I read, and so I don't know that I have all the details to give you the answer to that question precisely. And maybe I can do that in writing later on.

Mrs. BLACKBURN. That is acceptable.

Mr. DEEDS. The part of the bill that I really like are the changes to HIPAA. I hear from so many people—I mean since my son died, the last 19 months I get messages, I get e-mail, I get Facebook messages, I get contacted by people all over the country every day. Mothers and fathers, older brothers and older sisters who care for a loved one who has a mental illness, who can't get the information that they are in basically the same situation I am in, and I think——

Mrs. BLACKBURN. OK. So for you, the number one would be the changes to the HIPAA laws.

Mr. DEEDS. HIPAA, yes.

Mrs. BLACKBURN. You like that. That is something that would help you as a caregiver.

Mr. DEEDS. It——

Mrs. BLACKBURN. OK.

Mr. DEEDS. I mean nothing is going to help me. I am done.

Mrs. BLACKBURN. Yes, sir——

Mr. DEEDS. But it is going to help the next person.

Mrs. BLACKBURN [continuing]. I understand, but I mean to that type situation.

Mr. DEEDS. Right.

Mrs. BLACKBURN. And I appreciate that so very much. And I appreciate your willingness to work with us on this.

Patrick?

Mr. KENNEDY OF MASSACHUSETTS. Thank you, Representative Blackburn. I would say, obviously, we have all spoken about prevention as the main policy we should all adopt, but I don't want this hearing to end up becoming this false dichotomy that it is one or the other. Obviously, payers want to do it on the cheap. So if they can hire a bunch of peer support folks, they are going to do it. And if they can deny inpatient treatment, they are going to do it. So we just have to be mindful that one doesn't preclude the other.

I like the recovery model. I am a beneficiary of the recovery model. But God forbid we use that as an excuse to preclude the medical treatment that people need when they are in crisis. This is not an either/or issue. We need both. And so I would say that. And I would finally say this. 42 C.F.R., if we are going to move forward in the 21st century, we need to have brain illnesses included in your medical record or else we are never going to get the comprehensive support that——

Mrs. BLACKBURN. OK.

Mr. KENNEDY OF MASSACHUSETTS [continuing]. Someone needs in their care. And I love that about——

Mrs. BLACKBURN. OK, so we have HIPAA and we have a both-end approach, not an either/or.

Mr. KENNEDY OF MASSACHUSETTS. Yes.

Mrs. BLACKBURN. OK.

Mr. Rosenthal?

Mr. ROSENTHAL. Thank you. The parts of the bill that I like the best are the focus on integration of health care and mental health care, and the better coordination of criminal justice in mental health. There is no question that so many of our most vulnerable people really have all these issues, and the coordination is essential.

In New York, thanks to the Affordable Care Act, they are implementing health homes which are linking all of these systems to work together. One staff person, one record, one plan.

The second thing, and I am really just not sure how to read the bill, but it looked like something we had talked about, Congressman Murphy, about outreach and engagement. You have a section in the block grant section which appears to say that you must have a good outreach and engagement plan in order to get the block grant, and that the strategies there may or may not have to have AOT in them. So I think a lot of us believe that this really aggressive but not coercive outreach and engagement, relentless outreach and engagement, is critical, and it seems like you are very focused on that, and I think that is tremendous. It is on the front end that we are going to have to do the most work.

And the third thing is the Interagency Serious Mental Illness Coordinating Committee. I think it really brings together all kinds of agencies and leads and expertise. The only thing I would say about that is it should include SAMHSA and the Centers of Medicaid and Medicare. It is the number one funding stream, Medicaid, is in America, and that is our best change. The outcomes associated with that, the incentives.

Mrs. BLACKBURN. All right.

Mr. ROSENTHAL. The things I like the least, well, assisted outpatient treatment really had its origins in New York in a very big way. I have been working in opposition of that for a very long time, and I do that because I don't believe it has been proven to be an effective strategy. There have been studies, first at Belleview, that gave everybody better services, and gave some court orders, and the study found it was the more and better services that got it done, not the court orders.

The legislature was so concerned about that that they ordered a comparison between voluntary and involuntary—am I out of——

Mrs. BLACKBURN. Mr. Rosenthal, I am sorry, my time has expired, and——

Mr. ROSENTHAL. Sorry.

Mrs. BLACKBURN [continuing]. If you can submit this——

Mr. ROSENTHAL. I will write it to you.

Mrs. BLACKBURN [continuing]. In writing. Thank you all so much.

Yield back.

Mr. PITTS. The chair thanks the gentlelady.

I now recognize the ranking member of the full committee, Mr. Pallone 5 minutes for questions.

Mr. PALLONE. Thank you, Mr. Chairman.

I wanted to ask my questions of Mr. Rosenthal. We can't talk about mental health coverage without talking about the Affordable Care Act's Medicaid expansion. Can you comment on how Medicaid expansion has expanded access to mental health and substance abuse services? And I ask that because, to put this in context, 22 states have declined to expand Medicaid at this time, leaving 3.7 million uninsured adults with serious mental illness unable to obtain coverage. And I hope those states will see both the economic and moral benefit of Medicaid expansion, sooner rather than later. And your answer to this question may provide some reason as to why they should do that.

Mr. ROSENTHAL. Thank you. The Medicaid program of the past was a very rigid and limited program, very focused on illness and symptom management but not, as I said earlier, about all of the domains of recovery that are essential.

We now have in this country a Medicaid Expansion Program and a greater use of Medicaid managed care, where the focus is on outcomes and improved services, and a diversity of services, including supports for even the social nutriments of health; housing, employment, things that really matter in peoples' lives. So the expansion, I think, really brings in people who currently are shut out, including people in addiction recovery and some of the programs that they require. So it is an extraordinary time to watch Medicaid reform and Medicaid expansion because I think millions and millions of Americans, without getting access to that, will be shut out and will be subject to poor care and poor treatment.

Mr. PALLONE. I mean is it fair to say that lack of insurance coverage is not only a significant barrier, but maybe the most significant barrier to someone receiving consistent care for a serious mental illness?

Mr. ROSENTHAL. Absolutely.

Mr. PALLONE. OK.

Mr. ROSENTHAL. And you know where that really turns up is people who are in jails and prisons who lose their Medicaid, it is shut off, and at that critical moment of discharge, planning, if the Medicaid is not in force, people fall within the cracks.

I read somewhere that people in addiction, if they don't get help in 20 days, 30 percent of them die. It is a very strong figure. So Medicaid access is critical, and in that system in particular, people are leaving jails and prisons without the services they need, and that is why we get so much re-incarceration and tragedy.

Mr. PALLONE. All right, I wanted a second question about Programs of Regional and National Significance, the PRNS. H.R. 2646 would create new grant programs that would be funded through a 20 percent cut on Programs of Regional and National Significance, and on SAMHSA's general funding authority. And I wanted to focus on the possible effect of a 20 percent reduction in funding for PRNS grant programs. SAMHSA's Center for Mental Health Services currently funds mental health first aid training for teachers and other adults who interact with youth. That training equips them with the tools needed to detect and respond to mental illness

in children and young adults. That PRNS program received $15 million in fiscal year 2014 and 2015 to provide grants to states and local education agencies.

So, Mr. Rosenthal, if SAMHSA's PRNS authority was reduced by 20 percent, $3 million would potentially have to be cut from that program. In general, what would a 20 percent cut in grant funding for community programs mean to those existing programs?

Mr. ROSENTHAL. Well, I think it would be a loss of access for many, many Americans in need. Certainly, the Mental Health First Aid Program has been so critical in educating the communities, the police, other important groups, and if that is cut, then that is that many communities and that many people and families who won't have the benefits of first aid.

I am not familiar enough with all of the Programs of Regional and National Significance, but I reviewed them briefly, and there are a number of recovery programs that, if they were cut by 20 percent, again, where there is a real emphasis on AOT and not enough, I think, on the recovery side of things.

Mr. PALLONE. Well, in addition to cutting mental health programs, H.R. 2646 would cut substance abuse programs to pay for those new mental health programs. A program that could be cut is funding for states to enhance or expand their treatment services to increase capacity and access to evidence-based Medication Assistance Treatment, or MAT. And the fact is America is facing a public health crisis related to the misuse and abuse of opioids, and we should not be cutting, in my opinion, any funding for that or for other SAMHSA substance abuse programs.

Thank you, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman.

I now recognize the vice chair of the subcommittee, Mr. Guthrie, 5 minutes for questions.

Mr. GUTHRIE. Thank you, Mr. Chairman.

Senator Deeds, I used to serve in the Kentucky State Senate, and you mentioned in your testimony that you had bipartisan efforts at the state level. You didn't really elaborate on those. Can you just kind of—for a few minutes of—about a minute or so, what you did, and then how the Federal Government can help states doing what you want to do there?

Mr. DEEDS. At the state level, when I went back to the General Assembly just a few weeks after all of this happened, to me, my scars were red and my eyes were too. People there knew me because I have been in the General Assembly for a long time. I am a bipartisan guy. I am a partisan democrat, but I have friends on both sides of the aisle. They knew my son, because he had been on the campaign trail with me for years. So I was able to cobble folks together to get things done, but the reality is that funding is not as consistent as it needs to be across the board. We need federal organization. And what this bill does in many respects is it takes funding and reorganizes it in a way that makes more sense, I think, makes more sense for the states, makes more sense for the country.

Mr. GUTHRIE. Well, thanks. And I was going to ask Mr. Kennedy, my friend, Patrick, this, but you mentioned HIPAA and how did HIPAA specifically block what you were hoping to do, or how did

it affect your situation? I understand that as a caregiver, you can't get the information you need.

Mr. DEEDS. Well, I couldn't get psychiatrists to talk to me or to even return my calls. I couldn't get people in hospitals to tell me anything about what was going on with my son. And he was wary of me in the first place, so when I got him to go places, I tried for a long time to get him to sign a power of attorney or to sign a medical power of attorney to give me access to information. I tried to get him to give me that authority on some forms that other people had prepared for him, and he just wouldn't do it. And the providers wouldn't talk to me. I had one provider that sat down and talked to me, probably broke the HIPAA law, and maybe it is a lack of understanding of the law, but if it is, it is widespread.

I got an anonymous letter just about 4 months ago from a person who told me that he or she had provided care for Gus, and had told me some things that touched my heart about their treatment of him. I just didn't have the information beforehand. It seems to me, let me just tell you. One woman called me, or she called my office. She tried to get her adult son committed through an involuntary process. She was successful. But in the hospital, they wouldn't tell her where her son was going.

Mr. GUTHRIE. Yes.

Mr. DEEDS. So she couldn't get him his things, she couldn't talk to anybody there about his experience. That facility wouldn't even return her calls. They just put him on a bus and sent him home. How in the world is he going to be kept to schedule, is he going to take his medications, is he going to keep his appointments if somebody doesn't know it? That is——

Mr. GUTHRIE. Understand.

Mr. DEEDS. That is what this legislation——

Mr. GUTHRIE. Thanks. I have one more question—well, it is not really a question, but Ms. Billingsley brought up some concerns. And we want to solve problems, not raise more concerns. And talked about the PAIMI program, and if I could yield to my friend from Pennsylvania to address some of the concerns that you brought up, I would like to do so.

Mr. MURPHY. Well, let me just say this. With regard to some things on the protection advocacy issues, now, I can't say that there is much that this panel has said that I don't agree with, and it sounds like some clarification of wording. Our bill does not require assisted outpatient treatment. It does not, and that is a misnomer, and I see that in the minority memo, so let's make sure we are clear on that. We recognize it can be valuable for some people, particularly those who are cycling in and out of jail, those of have history of violence. We just saw that happen down in Dallas, Texas. I think it can help in some cases, but it is not a panacea. But I want to make sure that we are focusing on this, and worded this in such a way that people can get help and can get that advocacy. It is against federal law to use it for lobbying, and I don't intend to change that law, but I want to look at something that does need to change. And just to follow up on what you were saying to Senator Deeds about some individuals have claimed that with regarding to releasing any information under HIPAA, it has to be "as necessary to prevent or lessen a serious and imminent threat to the

health or safety of a person or the public." So that is the limitation. Do you agree with that kind of limitation?

Mr. DEEDS. I might take it a little broader, but I think that that protects a person's privacy. Somebody has to make a decision that it is necessary that the person doesn't understand what is in their best interests, and that the caregiver will provide for that.

Mr. MURPHY. Which is important, and that is where I think our bill tries to broaden that. If that person is not aware, to provide you with a diagnosis, treatment plan, time, and place of the next appointment——

Mr. DEEDS. That is right.

Mr. MURPHY [continuing]. Medications, that would be helpful to you as a parent?

Mr. DEEDS. That would be very helpful. Critical.

Mr. MURPHY. I will go back to my questioning later. Thank you.

Mr. GUTHRIE. Thanks, and my time has expired. I yield back.

Mr. PITTS. The chair thanks the gentleman.

I now recognize the gentlelady from California, Mrs. Capps, 5 minutes for questions.

Mrs. CAPPS. Thank you, Mr. Chairman. And thank you all for your amazing testimony.

For too long, mental health has been left out of our discussions about health. I am happy that members of this committee on both sides of the aisle have a shared interest in addressing this important issue. My background is a public health nurse, worked in our community schools. This is an issue I know well. I have a brother who has a history of being bipolar. I know it personally very well.

Thankfully, we have made great strides in recent years, most notably that all plans must now follow mental health parity rules. Many previously uninsured and underinsured individuals with mental illness now have access to insurance. This was the greatest expansion of mental health services in our history, but now one that needs to be built upon. And as written, I am concerned that my colleague, Mr. Murphy's, bill does not comprehensively advance this progress enough. We need to work together to do so, because it does little to address mental health issues before they reach that crisis level, help individuals after the crisis point has passed. It pits mental health and substance abuse services against each other, despite the fact that for so many individuals, these are intertwined ailments, and needlessly injects partisan politics into the mental health space by attaching extraneous abortion language. We don't need to be doing that here. It is not a way to move a bipartisan bill forward to make meaningful change. Our Nation has a history of reacting to mental health issues in a very erratic way, swinging from one extreme to another. We need to stop the swing, and enact thoughtful evidence-based policies if we really truly want to make progress.

I am hopeful that today's hearing is going to help us look beyond a particular bill, and help us have that constructive dialogue to move in a positive way.

Ms. Billingsley, at a previous hearing on this issue I was particularly moved by a woman's testimony where she described the abuse that took place in her group home, and how the protection and advocacy for individuals with mental health program, PAIMI——

Ms. BILLINGSLEY. Yes.

Mrs. CAPPS [continuing]. Helped shut it down and bring her and her housemates to justice. I will never forget her testimony. Similar to what you have talked about today. It is equally notable. But as you noted, the Murphy bill would tie some of the program's hands to protect these individuals from unlawful discrimination from educating policymakers like ourselves about the issues that these individuals face. I think that seems really shortsighted. If the PAIMI program is prohibited from advocating for the rights of an individual with mental illness, where will families turn to ensure the enforcement of laws and regulations?

Ms. BILLINGSLEY. I don't know where they would turn, and quite honestly, I don't know where our family would be if we had not had their help. I can't even imagine where we would be. I often think, and coming here today has brought back quite a bit of this journey for our family, it is possible my son wouldn't be alive today. It is quite possible——

Mrs. CAPPS. That bad.

Ms. BILLINGSLEY [continuing]. Because of the downward spiral he was in, and we were no longer able to help him. So if that funding was not there, I don't know what we would have done.

Mrs. CAPPS. Programs like PAIMI are so critical, and you said it, to ensuring that families and individuals with mental illness have advocates ensuring that their rights are protected. We don't want, as it seems to be the case in this bill, to tie their hands, and that is another indication in my mind that we can do better.

One bill I am particularly interested in was written by my California colleague, Representative Matsui. Her bill, it is the Including Families in Mental Health Recovery Act of 2015, would clarify HIPAA privacy rules, and would educate providers, patients, and families about the law as well.

Mr. Rosenthal, may I turn to you? Do you think health providers adequately understand what HIPAA permits if a patient is in a crisis situation? In other words, do we have a problem with provider education——

Mr. ROSENTHAL. Absolutely.

Mrs. CAPPS [continuing]. Or do we need fundamentally to rewrite our privacy laws?

Mr. ROSENTHAL. I think education is critical. I think HIPAA, as I understand it, and also sort of codified, if we could codify OCR, the Office of Civil Rights, sort of guidance would make it even clearer, but I know that providers at minimum are confused or frightened, and at worse, are hiding behind HIPAA rather than really—they can listen to families now. They may not be able to disclose everything, and there are circumstances where they can and they should, and they don't. So I think—absolutely, I think education is critical. We can't do enough——

Mrs. CAPPS. So that is an indication of the ways that we have to move past where we are today, even considering this bill.

I am out of time. I will yield back.

Mr. PITTS. The chair thanks the gentlelady.

I now recognize the gentleman from Illinois, Mr. Shimkus, 5 minutes for questions.

Mr. SHIMKUS. Thank you, Mr. Chairman. And thank you all for being here, and for my colleagues for their great questions. I just would encourage my colleagues that if we want to have an opportunity to really move a bill, we are going to have to come together and be positive and just tweak the language and work this through. My colleague, Mr. Murphy, has worked real hard. Patrick, it is great to see you again. Senator Deeds and the folks' testimonies are just heartbreaking.

And so the easy question, how many of you on the panel are parents? Raise your hand if you are parents. OK. Everyone is a parent. So my question is, when do we stop being a parent? I don't think we do.

Ms. BILLINGSLEY. No, we never do.

Mr. SHIMKUS. You know, my mom and dad, thankfully, are going to celebrate their 65th wedding anniversary, and if I do something wrong, they are in my face.

So this HIPAA debate—I said that, didn't I? Dang. That is our secret. Don't tell anybody. But this HIPAA debate is very, very important, and I think we really need to get it right. I still have young—not young, but young men who, some of this onset comes at different times. And I fear the day where they need help and we can't get access to information. And so I am very encouraged by the talk and this whole debate because we want to be engaged.

My question is to Dr. Lieberman on—asking you if you have any sense of what kind of clinical outcomes are associated with the emergency department overcrowding for patients requiring medical or psychiatric services?

Dr. LIEBERMAN. Well, the overcrowding and the increased demand relative to capacity simply sort of backs up people who are waiting to be seen, makes the health care personnel kind of rushed in the process of being able to do the evaluation, and then if the disposition is hospital admission, which it frequently is because there is a paucity of available beds, they must sit there. In New York State, there is a law that you have to make a disposition of somebody in an emergency room within 48 hours. It sounds long, but many people sit there for longer. We have had patients in the emergency room for as long as 6 months. That means they have to be fed, bathed. And the reason why this occurs is because if you have what is called an intellectual or developmental disability, autism, Fragile X, any of the genetic neurodevelopment disorders, and a complicating psychotic disorder, there is no place for you to go. So it is ridiculous.

But it really prompts me to sort of comment on some of the discussion we have had here about the various programs, Community Access and so forth, Harvey Rosenthal's excellent work as a rehab director. We are not having a discussion about excluding programs, but this is all part of a comprehensive effort. Mental health care is disease management, it is not simply a doctor giving a pill, or a rehab counselor, finding housing or teaching a skill. But when you have cancer and you have to go—let's say you have breast cancer or prostate cancer or—you go and make a recommendation, surgery, possibly radiation and chemotherapy. If the surgery disrupts your musculature, you might need rehab. Oftentimes there is a psychiatric component to it. All of these things are a part—right

now, we can't provide those because there is not a collocated availability of these services, and a revenue stream for financial reimbursement. So it is all fragmented, and as a result of this—and I appreciate the effort here because this—if anything can rise to be a bipartisan cause, this should be. This is not like we have to discover something new and mysterious. The expertise, the tools are available, we simply have to develop the policy to be able to orchestrate it. And what concerns me is that ideological issues are permeating and kind of diverting attention from the real issues. If you look at SAMHSA's Web site where they have a list of 360-plus interventions, there is no mention of medication. Now, I am not a cowboy doctor that is going to prescribe massive drugs and say, "See me in a month," to people. That is not what physicians do, and it is certainly not what psychiatrists do. But how can you have a list of interventions with no medication? It is like if you are going to go—it is like Steven Jobs, he refused surgery because he wanted to try a naturopathic approach. It shouldn't be exclusionary. We need to have a big picture approach to this in order to be able to really deal with this problem. And how long is it going to take us to appreciate it? How many Newtowns, how many Aurora, Colorados, how many Jared Loughners, is it going to take for this to happen?

Mr. SHIMKUS. My time has expired so thank you.

Mr. PITTS. The chair thanks the gentleman.

I now recognize the gentlelady from Illinois, Ms. Schakowsky, 5 minutes for questions.

Ms. SCHAKOWSKY. Thank you, Mr. Chairman. I apologize to the panel, there are concurrent hearings going on.

I want to especially welcome my friend, Patrick Kennedy, for being here. And of all the ways that you have contributed, the many ways, I want to thank you for decreasing the stigma attached to mental health issues. Thank you for that, Patrick.

Before I begin my questions, I want to first say I am very concerned that we are unnecessarily seeing antiabortion language included in this bill. We do not need to attach this kind of restrictive language on programs that help to prevent suicide and provide transitional housing for people with mental illness. And moreover, the language in this bill actually goes a step beyond the Hyde Amendment and restricts funds from being used to refer a woman to abortion services and, if anything, a provision that would probably guarantee increased mental anguish. Women deserve to have access to the full range of health services. At a minimum, have a right to know what services are available to them. So this language continues a dangerous precedent of attaching language restricting a woman's access to reproductive health services in bill that address different topics.

But let me move on. I would also like to address the drastic changes H.R. 2646 would make to the Protection and Advocacy for Individuals with Mental Illness Program. In Illinois, our protect and advocacy organization, Equip for Equality, has worked tirelessly to advocate for individuals with disabilities for 30 years. Not only has Equip for Equality secured housing and services for individuals with mental illness, but they have also worked to affect public policy. For example, they worked with state officials to cre-

ate an adult protective services system which works to prevent abuse, neglect, and exploitation of adults with disability. They also have advocated for the continuation of services that will allow medically fragile children to remain in their communities rather than in institutions, and yet this legislation would actually prevent Equip for Equality from doing this important work.

So, Ms. Billingsley, I want to thank you so much for joining us today to share your personal story of your family and son, Tim. As important as it is for PAIMI to address abuse and neglect, many people like Tim face hardship due to their mental illness because of discrimination and navigating the complex mental health care system. Families are often not able to find the help their family member needs, regardless of how hard they try. I have actually experienced that in my own family.

You said in your testimony that Tim is just 22 years old. Could you further elaborate in how Tim's illness manifests itself, and why it is important to Tim to be in the community?

Ms. BILLINGSLEY. Tim is going to be 23 next month, so he is pretty excited about that. The way his mental illness manifests itself is that he is highly needing to have structure on a regular basis for him, and he is a very talkative person, and he is very social. And if he is isolated for very long, he acts out with that. That goes against what he wants to be around with—or be with people. He also has a seizure disorder, and I bring that up simply because he needs to have family and community around him to help take care of that issue if that were to come about, and we have had a few situations with that. He currently lives in a home with five other young men, and he is very hasty to tell me it is time for you to go, which took me a little getting used to, to be quite frank. But he has a full life without me, and he needs that community setting to live his life well beyond the time I am here.

Ms. SCHAKOWSKY. So let me ask you this. Do you think you have would have been successful in securing Tim's right to stay in the community if the Disability Right Center of Kansas had not been allowed to advocate on his behalf?

Ms. BILLINGSLEY. No, there is no way.

Ms. SCHAKOWSKY. What would have happened then?

Ms. BILLINGSLEY. It is kind of similar to what else has been shared here today. We wouldn't get phone calls returned. We wouldn't get responses when we asked about programs. We were on waiting lists for services during a time in which my son would become violent at home, and there were concerns with the safety of our own family. If we had not had their intervention, as has mentioned here within 48 hours, when we needed it, we would have to have been hospitalized, I am sure.

Ms. SCHAKOWSKY. Thank you. I would like to ask unanimous consent to put into the congressional record, Congressional Research Service memorandum.

Mr. PITTS. Without objection, ordered.

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

Ms. SCHAKOWSKY. Thank you.

Mr. PITTS. Gentlelady's time has expired.

Ms. SCHAKOWSKY. Thank you very much, I yield——

Mr. PITTS. The chair now recognizes the gentleman from Pennsylvania, prime sponsor of this legislation, Dr. Murphy, 5 minutes for questions.

Mr. MURPHY. Mr. Chairman, before I start, I just want to ask that a couple of things be submitted to the record. One is the GAO report this committee requested called Mental Health HHS Leadership Needed to Coordinate Federal Efforts Related to Serious Mental Illness. [1] Second is the GAO report requested by this committee called Mental Health Better Documentation Needed to Oversee Substance Abuse in the Mental Health Service Administration. [2] Third is from the HHS Office of the Assistant Secretary for Planning and Evaluation, called Evidence-Based Treatment for Schizophrenia and Bipolar Disorders and State Medicaid Programs. And finally, a list of materials I would like to submit for the record, the statement from the American Roundtable to Abolish Homelessness, and letters of support from the American College of Emergency Physicians, the National Council for Behavioral Health, the National Alliance on Mental Illness, the American Psychiatric Association, the American Academy of Child and Adolescent Psychiatry, and the American Psychological Association.

Mr. PITTS. Without objection, so ordered.

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

Mr. MURPHY. Thank you.

It is an amazing day that all of you are here, and Congress is gathered to talk about such a critically important subject. Let's not forget that. We have a massive amount of common ground here. We have to link arms together and do this. And I thank my colleagues for their thoughtful comments in this as well.

Let me dig down in a couple of these things which I think are important in this bill. Mr. Gionfriddo, in this bill, we lay out a greater emphasis on secondary and tertiary prevention, and say you have to put some more dollars into child and adolescent areas rather than wait until later on. Could you describe why that is important to you, why you think it is important to focus on those areas?

Mr. GIONFRIDDO. Well, I think it is critically important to focus in on children. The date are 50 percent of mental illnesses manifest by the age of 14; ¾ by 25. But for a lot of us the statistics don't matter. My son was 5 when he developed signs and symptoms of schizophrenia. And he got the 10-year delays everybody else gets by the time he got his final diagnosis, 10 years that we lost opportunity after opportunity to change the trajectory of his life. That is one of the reasons he is homeless now, not by his choice, but by choices we made as policymakers to do that. It is critically important we move upstream. We have to arrest this at stage 1, 2, and 3. We can't keep waiting until stage 4. We can't keep waiting for crises to occur, we can't keep waiting post-crisis, we have to move upstream. That is why it is important to me.

Mr. MURPHY. Now, I might add for my colleagues, what I mean by primary prevention is what we tell everybody, secondary preven-

[1] The report has been retained in committee files and is also available at:*http://docs.house.gov/meetings/if/if14/20150616/103615/hhrg-114-if14-20150616-sd017.pdf.*

[2] The report has been retained in committee files and is also available at:*http://docs.house.gov/meetings/if/if14/20150616/103615/hhrg-114-if14-20150616-sd014.pdf.*

tion is now you identify the high-risk group, and tertiary is someone who is with symptoms. And that is important because, as we go through in the grant programs what the GAO report said about SAMHSA is, quite frankly, they weren't documenting, they weren't evaluating, programs that got grants didn't stick to their grants, so it is important we have that oversight.

I also want to note with regard to the issues with regard to Medicaid services here, that in this report from Office of the Assistant Secretary for Planning and Evaluation, it said only 45 percent of beneficiaries with schizophrenia, and 35 percent with bipolar disorder, maintained a continuous supply of evidence-based medications, and received at least one psychosocial service during the year. In other words, these reports are saying our system is failing pretty bad in this.

Patrick Kennedy, you and I have talked a great deal about this issue of an Assistant Secretary, and their role to get the Federal Government coordinated in these symptoms, to follow through on parity, and to report back to Congress. You have been here. You understand what it is like. What do you see the value of having someone go through these 112 federal agencies, get the data from the states, and keep Congress' feet to the fire in this? What do you see the value of that in moving forward in the long run?

Mr. KENNEDY OF MASSACHUSETTS. Well, thank you, Representative Murphy. First, to your previous question to Paul, would say we could solve this crisis tomorrow if we intervene on first incidents of schizophrenia. There is no mystery in this country how to avoid the over-hospitalization and crisis management. We are picking up the pieces after people have fallen off the cliff. We know what to do. Intervene right away with first onset. Don't let the time lapse. And as Paul said, you permanently change the trajectory of those people. So for people who are interested in return on investment, your investment is a lifelong disability is averted if you do that wraparound services, first incident.

So, Representative Murphy, I appreciate that being a major focus. The raise work that is being done now is the model. Naples is the model. The prodromal phase scientifically before symptoms is really what our Holy Grail should be. And we can do that with scientists like Jeff Lieberman.

To the answer on accountability, we are in a new post-parity world. We have the legal infrastructure to appeal when people aren't being treated equitably under the parity law. And I appreciate the fact in this legislation you have a specific GAO report evaluating non-quantitative treatment limits. That is the secret way that insurance companies deny care. They keep it behind, of course, we have eliminated the quantitative treatment that sets premium discrimination, copay discrimination, lifetime limit—that is gone. So now where has the discrimination moved? It has moved to this non-quantitative treatment limit.

If we expose that, which your bill, among many other things calls for greater transparency and accountability, I am telling you, you are going to see a sea change in the way that we move towards this problem, because we are not going to be waiting for it to become crisis. It is going to be evident to insurers that it is more cost-effective for them to intervene early. So I appreciate that. And the state

reporting is key because, as you acknowledge in this bill, it is the states' mandate to continue to work in implementing this law. We need to have an accountability structure to see how they are doing, and I appreciate that also being in this legislation.

Mr. MURPHY. Thank you.

Mr. PITTS. The chair thanks the gentleman.

I now recognize the gentlelady, Ms. Castor, 5 minutes for questions.

Ms. CASTOR. Well, thank you, Mr. Chairman and Mr. Green, for calling this hearing today. And I want to thank the panel for relaying a sense of urgency for the Congress to act when it comes to mental health. And thank you for your expert recommendations on how to improve the bill today.

And, Congressman Kennedy, it was great to see you a few months back at the Florida Mental Health Research Institute in Tampa, at the University of South Florida. They presented Congressman Kennedy with the Humanitarian Service Award that is very well-deserved. So it is great to see you.

I want to keep the focus on implementation of the Mental Health Parity Act. There is an important provision in the draft bill that would require the Department of Labor to submit a report to Congress identifying federal investigations conducted or completed during the previous year regarding compliance with parity in mental health and substance abuse disorders under the Mental Health Parity Act. Remember, that Act enshrined in law that principle that mental health is equivalent to physical health. And the law required group health insurance plans covering mental health and substance abuse services to cover them at parity with physical health services.

Then the Affordable Care Act extended this principle to the individual health plan market. It also requires that all expanded Medicaid programs, as well as individual and small group health insurance plans, cover mental health and substance abuse services as part of the essential health benefits package. That is critical. The ACA expanded these benefits and parity protections for 62 million Americans.

But Congressman Kennedy, in the beginning of your testimony you referenced the difficulty with implementation. You are hearing about insurance companies' compliance or noncompliance with the parity requirements, is that accurate?

Mr. KENNEDY OF MASSACHUSETTS. Absolutely accurate. And if members want to make a difference tomorrow on getting more people care than they have today, write a letter to Secretary Perez from the Department of Labor, because Secretary Perez can issue greater guidance on all ERISA plans, that is employers' insurance plans, that this should be a greater evaluation on whether they are complying with a federal law. He can issue guidance tomorrow. He needs to hear from you that you want him to do that, because 65 percent of the health market is that employer-sponsored health care. And our veterans, by the way, are going to depend on their health plans, if they are employed, having coverage for their signature wounds of war.

Two, you could write a letter to Secretary Burwell from HHS. She has the authority today to issue greater disclosure require-

ments on all insurance companies so that we can better understand how they do medical management, because as you know, Representative Castor, the key to this is the utilization management, how they move those things around. We under parity, by necessity, need to know how to compare the way they do utilization management for the mental health patient, to the way they do utilization management for the stroke patient, for the cancer patient, for the diabetic. If we know how to draw those analogs, we can enforce parity because the law would require that they do something different than they are currently doing.

Ms. CASTOR. Other panel members, are you hearing about difficulties with implementation of the important goals of mental health parity? Mr. Gionfriddo?

Mr. GIONFRIDDO. Absolutely. I think that everybody understands that the law has changed, but the implementation law hasn't fully taken place yet. And we deal with this every single day at Mental Health America. We are hearing a lot about this, and strongly endorse efforts to try to make certain that we realize all the benefits of parity for all the people we care about.

Ms. CASTOR. Mr. Rosenthal?

Dr. LIEBERMAN. I can——

Ms. CASTOR. Yes, go ahead.

Dr. LIEBERMAN. I can add to that. When I was in my role as President of the American Psychiatric Association, we had to make decisions about which litigation to pursue against various insurance companies that were denying benefits or not complying with the parity law. And what it ultimately came down to was the fact that we had a very strong case in almost all instances, but there were such deep pockets on the side of the insurers that financially, they just drained us. And so it became a much more complicated sort of battle to fight, and I think we are still engaged in that battle.

Ms. CASTOR. Well, I want to thank you all. Really, I think with Mr. Murphy's help, we can look at ways to improve this. If you all, when you are submitting comments back to the committee, would make some specific recommendations here. And I also appreciate Ranking Member Pallone bringing up the Medicaid expansion, the importance of it. The State of Florida, unfortunately, just last week, rejected a republican State Senate plan to expand Medicaid in Florida. That leaves about 800,000 of my neighbors across the State of Florida in that gap, leaves billions of dollars of our taxpayer dollars here in Washington, rather than bringing them back home. So if you all can talk to policymakers in the State of Florida, please relate to them how important Medicaid expansion is for mental health services.

Thank you.

Mr. PITTS. The chair thanks the gentlelady.

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

Mr. GRIFFITH. Thank you very much, Mr. Chairman. Thank you, members of the panel, for being here this morning, particularly Senator Deeds. It is so great of you to be here. Your story is obviously very compelling, and when the incident occurred with your

son, the entire region was affected by it. And we appreciate you being here.

That being said, one of the reasons I asked to be on this particular subcommittee was so I could talk about rural health care issues. And how long have you been in the state legislature, 24 years?

Mr. DEEDS. Twenty-four years. Got there one term before you.

Mr. GRIFFITH. That is what I was thinking. And you live about, what, 9 or 10 miles outside of the 9th Congressional District?

Mr. DEEDS. I used to be one of only two members in the State Senate that was on the dirt road, off a dirt road caucus, but the other fellow retired, so I am the last one that lives on a dirt road, off a dirt road.

Mr. GRIFFITH. There you go.

Mr. DEEDS. It is about 9 miles out of the 9th District.

Mr. GRIFFITH. So that brings up the issue, you worked very hard and got some great legislation through in Virginia to make sure that there was a mental health bed registry available to the people of Virginia. But I noticed in an article late last year that Eastern State is getting a lot of patients because they are the location that has beds, and they are the beds of last resort. And I am wondering if we need to be thinking about encouraging the states to participate in a national bed registry, because you are also not far outside the 9th. How far are you from West Virginia——

Mr. DEEDS. I am not far from West Virginia at all, and I am——

Mr. GRIFFITH. Ten, 15 miles?

Mr. DEEDS. Probably a little bit further than that, but not very far. Twenty-five miles. And national registry might make some sense. It might make some sense, but as you know, and we in Virginia have also turned down the Medicaid dollars. They provide insurance to about 400,000 Virginians and about 162,000 of them have serious mental illness. Pretty significant for us.

Mr. GRIFFITH. Yes. And mental—I will agree with you that mental health issues are things that we need to take a look at and be very serious about.

I am also concerned about the HIPAA requirements that you weren't able to know. Whether it is a misunderstanding or not, we need to change the language to get rid of the misunderstanding——

Mr. DEEDS. Absolutely. Yes.

Mr. GRIFFITH [continuing]. To make it clearer. I think this bill does a lot of that. One of my concerns is, and I know you have only read the summary of the bill, is that in the sections on HIPAA, we get family members involved, which I think is great. My concern is the family member—and I know you have practiced in this area, or at least most rural lawyers have, where somebody has abandoned the family when somebody is a juvenile, and you think it might be helpful if we put language in there. We have excluded people who have a documented history of abuse, but do you think it might be helpful if we also excluded family members who have abandoned a juvenile——

Mr. DEEDS. That——

Mr. GRIFFITH [continuing]. Before the incident—obviously, as an adult, but when they were a juvenile, abandon them?

Mr. DEEDS. I think that language needs to be clear. The summary I read does make clear that there has to be some kind of caregiver relationship between the family that is going to have information and the person that is affected.

Mr. GRIFFITH. And I appreciate that.

I have a little bit of time left. It is great to see you——

Mr. DEEDS. Thank you very much.

Mr. GRIFFITH [continuing]. And appreciate you being here. Is there anything else that we haven't touched on that you wanted to touch on?

Mr. DEEDS. I think we have touched on a whole lot, yes. Thank you. Thank you for asking.

Mr. GRIFFITH. All right, and we have.

Mr. MURPHY. Gentleman would yield time, or——

Mr. GRIFFITH. Yes, well, I can. The gentleman from Pennsylvania is requesting my time, and I would like to yield to Mr. Murphy.

Mr. MURPHY. I thank the gentleman from Virginia.

Dr. Lieberman, I want to clarify something about HIPAA, because I hear a lot of talk about it, but you are the only one on this panel, as I understand, who is a licensed provider who has to follow HIPAA laws in that sense as in your doctor role there. Is it just a matter of getting education out to other providers and saying if only you follow this, everything is going to be fine, or do you think there needs to be some changes in what you are allowed to tell loving, caring family members who are the provider? What do you think?

Dr. LIEBERMAN. Referring to in terms of the HIPAA——

Mr. MURPHY. In terms of HIPAA——

Dr. LIEBERMAN [continuing]. HIPAA discretions?

Mr. MURPHY [continuing]. I mean the restrictions at HIPAA now, what you are allowed to tell someone, is it just educating them or do we really need some changes?

Dr. LIEBERMAN. Right, it is certainly more than education because there is a medical-legal aspect to it that health care institutions are cognizant of, and doctors have the fear of God placed in them by not just their hospital CEOs but also the personal injury lawyers.

Mr. MURPHY. So right now then, and along those lines, if you were seeing Creigh Deeds, and he says, can you tell me about my son, can you just tell me what is his diagnosis, when is his next appointment, where is he, I want to get in there. Would you be allowed to say that as existing law is now?

Dr. LIEBERMAN. Right. Strictly speaking, no. If he is an adult, if he is overage, but if you did it, you would be doing it at your own risk because you could be sort of challenged. Doctors often do that, but I don't want to get into that because it is the commonsense thing to do.

Mr. MURPHY. OK, thank you.

Mr. GRIFFITH. I yield back.

Mr. PITTS. The chair thanks the gentleman.

I now recognize the gentlelady from California, Ms. Matsui, 5 minutes for questions.

Ms. MATSUI. Thank you, Mr. Chairman. And I want to thank all of you for being here today. Your testimonies have been very compelling, the full range of mental health.

And first of all, let me just say I agree with Congressman Kennedy about the continuum of care. We should not allow prevention, intervention to go against the serious mental illness. It is just a continuum of care. This is what we are talking about today. And the emphasis should be on the mental health of an individual. And I believe in prevention and intervention at the early end, and all of the services that have to be provided, and that has been my history. I have always been feeling that way. And I think that what is really important here to look at too is the fact that we have been focusing many times here on serious mental illness, because we know how tragic that is. Whether or not it ends tragically, I know in my family, I have a sister who has been severely mentally ill for a long time, and during that time, she really did not have the care because it was a long time ago. I think today she would probably be functioning much better, much like your son, Ms. Billingsley. But I would have to say this. I have been affected very much by the tragedies that have occurred. I have a couple of friends who have adult children who have, they felt, been limited by not being able to assist them. And listening to you, Senator Deeds, I feel that pain again. And I thought that the importance of this bill, because it covers such a broad range, and HIPAA has come up so very often, and I think that HIPAA should be not looked at as an enemy here, and we can't use it as an excuse either. I think we really need to figure out what can we do with HIPAA. And I have spent a lot of time thinking about this, and also asked myself what can we do about these situations when it feels like there is no communication and no one to turn to. And I really thank you for working with me to answer that question, specifically for these issues about sharing information and communications between providers and caregivers. We have to walk a fine line here. We must protect the patient's right to privacy, and protect them from those who don't have their best interests at heart, but we must also empower families and loved ones to be able to help.

I think my bill strikes that balance. It is not a wholesale change. I don't believe we can do that because HIPAA should cover both mental and physical illnesses. It just can't be one versus the other. This bill is really supported by mental health advocates that really fall on both sides of the mental health policy issues, as well as groups in between. Groups like the American Psychiatric Association, the Bazelon Center for Mental Health Law, the Mental Health Association of California. And additionally, I thank Congressman Kennedy and the Kennedy Forum for recognizing the importance of this bill. I thank NAMI, the Treatment Advocacy Center, the National Council for Behavioral Health, the American Psychologic Association, and others for their help. I really feel that this is something where we just can't just say we are going to change it. We have to look at it to find out how we can change it, and I believe that this bill strikes the right balance.

And, Congressman Murphy, I also believe that your bill is something we can work with, and I would like to work with you on it. And I think you have heard from people on my side of the aisle

that they feel that there are really good points to this, and there are adjustments that have to be made, and I think people on the panel have expressed the same also. So I feel strictly that today we should feel heartened that we are actually drilling down and trying to find some solutions to this, and that to me is probably the most important outcome of this because, as we move forward, we pledge to do something here that makes real sense.

And just to comment on my bill here. Mr. Rosenthal, can you describe any situations where it would be important to protect the patient's right to privacy?

Mr. ROSENTHAL. I am struggling for a little bit here, I was caught off guard. Sorry. I think that patients really want to feel a sense of integrity and choice, and I think if they really are already feeling fearful, don't want to feel like their caregivers and the therapists are talking whenever possible about them without them.

Ms. MATSUI. OK. Can you think on the other side of this situation, when it would be appropriate and even necessary for a provider to communicate or share information with a patient's family?

Mr. ROSENTHAL. When somebody's health and welfare and safety are at risk, the person or someone else, I think that is critical. So I think those are critical sort of——

Ms. MATSUI. OK.

Mr. ROSENTHAL [continuing]. Considerations.

Ms. MATSUI. All right. I yield back. Thank you.

Mr. PITTS. The chair thanks the gentlelady.

The chair recognizes Dr. Murphy for a unanimous consent request.

Mr. MURPHY. Mr. Chairman, just to correct the record on the misrepresentation or perhaps misunderstanding about abortion. I ask that S. 1299, the Garrett Lee Smith Memorial Reauthorization Act, authored by Senator Jack Reed of Rhode Island, be introduced into the hearing record. It is Senator Reed's legislation, endorsed by the American Foundation for Suicide Prevention, which is identical to the language of H.R. 2646, the Helping Families in Mental Health Crisis Act on Suicide Prevention.

Mr. PITTS. Without objection, so ordered.

[H.R. 2646 is available at:*http://www.gpo.gov/fdsys/pkg/BILLS-114s1299is/pdf/BILLS-114s1299is.pdf*.]

Mr. PITTS. The chair recognizes the gentleman from Florida, Mr. Bilirakis, 5 minutes for questions.

Mr. BILIRAKIS. Thank you, Mr. Chairman. I appreciate it very much. And thank you for holding this hearing. Very important hearing.

Last December, I had the pleasure of hosting Congressman Murphy in Florida for a mental health roundtable with stakeholders from the community. I commend him for the extensive amount of time he put into addressing mental health and substance abuse disorders. I also serve on the Veterans Affairs Committee, where we have extensively focused on mental health issues plaguing our veterans, our true American heroes. In 2012, Time magazine wrote that more U.S. military personnel sadly have died by suicide since the war in Afghanistan began than have died fighting there. Mental health is an important issue, and I am glad we are addressing it. Thank you, Congressman Murphy.

A question for Dr. Lieberman. Dr. Lieberman, training for law enforcement that addresses how officers can best approach individuals with mental health or substance abuse issues has been extremely important in my community. Training programs that establish a partnership between law enforcement and mental health groups have effectively been implemented in my district. Since this legislation provides the creation of such programs, can you provide some insight about what effective training might entail, what should law enforcement be aware of when encountering individuals with mental health or substance abuse disorders in the line of duty, how could a lack of training cause an escalation in these encounters?

Dr. LIEBERMAN. Thank you for that question. This really is a very important but also unfortunate situation that has arisen in which the law enforcement and criminal justice system has become so intertwined with mental illness and mental health care. Every time I see a terrible story about a mentally disturbed individual being subdued and possibly injured or killed by police, I am thinking why are the police called upon to be first responders? That is really not their training. And similarly, in correctional officers in jails or prisons, because of the increasing number, that is not their training, and even if they do have some in-service training about this, it really is not sufficient.

So I think both criminal—and it is interesting you ask that because just this past Friday, I was speaking to 500 attorneys in the Manhattan District Attorney's Office. They asked me to come down to speak to them about mental illness, what the nature of it was, what it looked like, and also how could they try and adapt so that they could better manage the process of judicially reviewing cases of individuals who clearly have mental illness. So this is a growing problem.

I think training is important, both for the police as well as for the criminal justice system, but frankly, if we are going to basically launder our mentally ill through the criminal justice system, both juvenile and adult, we probably need to have mental health professionals embedded with the police and more present within the prisons, in the jails. This is the new normal or the new reality, and we need to provide care where it is required.

I was having a conversation with individuals at that meeting on Friday where I offered the observation that, in adult prisons, you have people principally who are adults, who are either psychotic, with schizophrenia, bipolar disorder, possibly psychotic depression, and substance abusing. Predominant diagnoses. In the juvenile detentions, it is kids who have what are regarded as antisocial behaviors and conduct, but in many respects, I would even venture to say it is the majority, these individuals start out as individuals who have learning disabilities or what is scientifically called pediatric cognitive disorders. They have dyslexia, they have ADHD, they have nonverbal learning disabilities, and they can't connect with the world socially, educationally, and because they aren't succeeding, they are getting kind of negative feedback, they react to it in an obstreperous or disobedient way, and that leads them down this path and they end up in prisons. So it gets to what Patrick was saying about, we are sort of addressing this downstream, clos-

ing the barn door after the horses have left. But either we give a modicum of training to our law enforcement and correctional people, or we embed mental health professionals or we really go for the big solution which is preempting the flow of individuals into the legal system to begin with.

Mr. BILIRAKIS. Thank you. Thank you very much. I will yield back. I don't have any more time. Thank you, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman.

I now recognize the gentleman from Maryland, Mr. Sarbanes, 5 minutes for questions.

Mr. SARBANES. I thank you, Mr. Chairman. I want to thank the panel. Patrick, welcome back. It is great to see you. I was talking to Dr. Nancy Grasmick the other day when I was working with you on brain research affecting early childhood, and she is incredibly excited about the work that you all are doing together. And I worked for her for 8 years, so I can tell you if she is excited, it has to be good stuff. So congratulations on that, and thank you for your testimony here today.

There is no question that we still live in a world where, when we see physical pain, our impulse is to treat it, and unfortunately, when we see mental pain, our collective impulse often is to look in the other direction. And the first step towards remedying that, a critical step, obviously, is to make sure that our health care system acts with the kind of parity that Patrick Kennedy and others fought so hard for, and is now embedded in the Affordable Care Act.

There is this tension as we think about how to distribute resources across a health care system that is more sensitive to issues of mental health between, sort of where along the spectrum do you place the resources to maximize the positive impact you can have. When you are talking about people that are on that spectrum of illness, intervening in an earlier stage may be intervening when the illness is less acute, more moderate. And so that is something that I know we are trying to sort out in the deliberations over this bill and other proposals that have come forward.

It occurred to me that a lot of the debate over what kind of information can be made available to parents, for example, or family members of people that are suffering from mental illness, occurs because those suffering are of adult age, and that is when these protections kick in, which, to my mind, just emphasizes the importance of early intervention, because presumably early intervention, intervention at first instance, as Patrick indicated, would oftentimes be intervention that occurs before the individual reaches the age of majority and these protections kick in. So if we could promote more of that, we are not going to be diffusing all the situations where you have these kind of competing considerations between privacy and delivering care, but we will be addressing a significant number of them. And also presumably, just promoting a broader and more open and more candid conversation among all the affected people in the equation so that you begin to build a relationship and a communication, a conversation, that can help support that individual as they move forward. One that includes family members and includes caregivers, and so forth.

And finally, early intervention, I presume, has to promote parity. And we talk about sort of legal parity and health insurance coverage parity, but the greatest challenge we face, obviously, is achieving parity in a judgment that society delivers upon one kind of illness versus another. And I think that we all want to get to a place where our reflexive response to someone who is suffering from mental illness is on par with the way we respond to those who are experiencing a physical trauma, kind of in the traditional sense.

I am committed to this ongoing conversation. I thank Representative Murphy for putting this in front of us for discussion. I thank Representative Matsui for her important contribution to the conversation. It is something we have to continue going forward.

And I don't really have any questions, just to thank you all for your testimony today. And I will yield back.

Mr. PITTS. The chair thanks the gentleman.

I now recognize the gentleman from New York, Mr. Collins, 5 minutes for questions.

Mr. COLLINS. Thank you, Mr. Chairman.

Before I get started, I just need to go out of my way to thank Congressman Murphy for his tireless work on the important issue we are here talking about. As a cosponsor of this bill last Congress, I am pleased to see this moving forward. This is certainly one step in that process. But I want to particularly thank Congressman Murphy for adding into this bill Section 207(d), a version of the Ensuring Children's Access to Specialty Care Act, which I introduced earlier this year with Congressman Joe Courtney. This provision adds child and adolescent psychiatrists to the loan repayment program in the National Health Service Corps, or NHSC, for those doctors who practice in underserved areas. I believe this is an important step forward in getting mental health treatment to children, and I will continue to work to ensure that all pediatric subspecialties are covered in the NHSC program.

I think we have covered a lot of the details today, but I did hear, Mr. Rosenthal, you mentioned, and I know you are a supporter of Obamacare, and we can all agree to disagree on certain things, you certainly let it hang out there that because of Obamacare, in the Medicaid expansion in those states that have accepted Medicaid expansion, they are offering significantly better different programs in mental health than the states that did not accept expansion. And I guess in the category of you don't know what you don't know is always—it has been my impression that with one minor exception, which is an optional minor demonstration program dealing with reimbursement for emergency inpatient psychiatric care, with the exception of that, the main thing that the Medicaid expansion did was change the income guidelines under which patients would qualify for Medicaid. States that accepted the expansion were able to get people in at a higher income level than states that didn't. But I wasn't aware that there was this wide area of different programming, et cetera, et cetera, going on. So I guess all I can do is say I kind of take issue with that piece of it which is kind of hung out there. But also I just want to bring up, we had under Chairman Murphy, a hearing on SAMHSA, and in that clearly, this committee was generally not happy with some of the outcomes, the ex-

penditures of money, and so forth. And I know I—correct me if I am wrong, but I think the majority of your funding comes from SAMHSA, so you are—doesn't. But I am assuming you are well versed in what SAMHSA does.

Mr. ROSENTHAL. I would say 3 percent of my funding——

Mr. COLLINS. OK.

Mr. ROSENTHAL [continuing]. Comes from——

Mr. COLLINS. But I know you do deal with SAMHSA and get——

Mr. ROSENTHAL. Yes.

Mr. COLLINS. OK. So I guess kind of as a pick-up on that particular hearing, I believe this committee would like more local control of dollars, good reporting coming back, because SAMHSA is a funding mechanism to get grants out. Could you share with us here your thoughts on SAMHSA and how we might have the taxpayer dollars go to better use with that funneling mechanism, have you got any recommendations? I don't know that it belongs in this bill or not, but we would just be interested in your observations there.

Mr. ROSENTHAL. Well, as I said earlier, I think SAMHSA really helped birth the recovery consumer movement, and my experience with them in the contracts that I am working on is really focused on peer support, health care integration, employment, things that are noncontroversial and very important and significant. I think that arguments have been made that SAMHSA needs to be more balanced, but I think that the solution of eliminating it is not the way to go. We will lose an important resource and decades——

Mr. COLLINS. Yes, I don't think that has been suggested, but like some government agencies, I think at some point more accountability, more metrics——

Mr. ROSENTHAL. I don't disagree with that, Congressman. I think——

Mr. COLLINS. OK.

Mr. ROSENTHAL [continuing]. SAMHSA needs more accountability.

Mr. COLLINS. Yes. Well, I appreciate all of your—you would like to make a comment?

Dr. LIEBERMAN. Yes, I mean SAMHSA——

Mr. COLLINS. You only have about 30 seconds, but——

Dr. LIEBERMAN. SAMHSA's budget is $3.6 billion. The NIMH's budget is $1.2 billion. SAMHSA's efforts to try and provide and innovate mental health care from the perspective of the academic psychiatric community has been a disaster. They have not had a psychiatrist in a significant position of leadership in that in a decade. There is an ideological bias which pervades the organization. In fact, I would go so far as to say that SAMHSA is a proxy agency for the antimedical, antipsychiatry approach to mental health care.

Mr. COLLINS. I can appreciate those comments, and certainly we continue to look to Chairman Murphy to lead our discussion in many of these areas based on his expertise. And while I don't think anyone would suggest SAMHSA go out of existence, I think we want to see our taxpayer dollars go where they should, and perhaps a rebalancing might be appropriate as we move forward, and we would certainly appreciate your input on that.

My time has expired, Mr. Chairman. I yield back.

Mr. PITTS. The chair thanks the gentleman.

I don't see any other Health Subcommittee members present, so without objection, we will go to—do we have——

VOICE. It is full committee.

Mr. PITTS. Full committee members. Mr. Tonko, you are recognized 5 minutes for questions.

Mr. TONKO. Thank you, Mr. Chair.

I think we need to identify for the record whether or not we eliminate the SAMHSA role with the creation of a new structure within the Secretary's position.

Mr. PITTS. Do you want to respond, Dr. Murphy?

Mr. MURPHY. What we do is we elevate SAMHSA from an agency to having Assistant Secretary of Mental Health and Substance Use be the head of that. And so it is not eliminated at all. It is elevated in terms of the authority of that. As you know, with these 112 federal agencies out there, someone needs to have enough strength behind their name and title to actually coordinate many aspects of this.

Mr. TONKO. OK. I think it certainly warrants further discussion. And Representative Butterfield had to leave. He has asked that I request that this article, Fatal Police Shootings in 2015 Approaching 400 Nationwide, be submitted to the record.

Mr. PITTS. Without objection, so ordered.

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

Mr. TONKO. And I thank you, Mr. Chair. And thank you as well to my colleagues. Certainly, Representative Murphy and Representative Matsui have been doing great work to introduce legislation that continues the conversation on how we can best address the needs of those struggling with mental illness.

While I continue to have a number of concerns with the Helping Families in Mental Health Crisis Act, I believe that it is a thoughtful and earnest endeavor, and it is my hope that we can all come together to move forward, address these concerns, strengthen the legislation, and produce a final product. I think it is very important that we do that, and that need has been expressed by several on the panel here this morning.

That being said, Mr. Gionfriddo, in your testimony you touched upon the issue of funding for the new programs included in this legislation, stating that it is emphatically the position of Mental Health America that any offsets should not come from existing community mental health programs. One of my concerns with this legislation as it currently is written is that it is ambiguous on the funding mechanisms of many of these programs, and where it does speak to funding specific programs, it often reauthorizes them at lower levels than currently funded. As the authorizing committee, it is our job to ensure that we put our money where our mouth indeed is, and provide clear and unambiguous funding instructions to the Appropriations Committee so that together, we can make the strong bipartisan case that more funding is needed for mental health and substance use programs——

Mr. GIONFRIDDO. Yes.

Mr. TONKO [continuing]. And can you please comment on this and, more generally, the need for this legislation to support not supplant existing funding for mental health and substance use programs?

Mr. GIONFRIDDO. Yes, I would be happy to. The first thing is that I would certainly encourage the committee to not make any doubt about the fact, or have any doubt about the fact that those dollars ought to come from someplace else. And, of course, I said in my testimony I think they ought to come from the jails and prisons. I think that is the place to get them from because that is the place they have been sent to.

Too many dollars have been cut. The states cut $4.6 billion from mental health agencies between 2009 to 2013, and here we hear that we only put the federal level $1.2 billion into IMH, and then SAMHSA only put $1.2 billion into the mental health side. That is ½ of what the states have cut is the total federal amount. So we can't continue to live with that. If the states aren't going to do their jobs, and they haven't been doing their jobs in this area, they just haven't, the Federal Government has to step in and figure out how to give them the guidance to make sure that they invest this way, and make sure they continue to invest early on in the process.

Mr. TONKO. Thank you very much.

And can I ask our other panelists to comment on that same question about supporting, nor supplanting existing funding? Senator Deeds?

Mr. DEEDS. Sure. I don't claim any expertise. I know about the Virginia system, but from my perspective, the system overall is not working. I don't think it hurts anything to examine the way you spend money and see if you can spend it more efficiently. I have been in the state legislature 24 years, I have never believed that you solve problems just by throwing money at them. But it is clear to me that in some cases, more funding is needed, but we have to make sure we are spending money as efficiently as we can right now, and I don't think we are.

Mr. TONKO. OK. Congressman Kennedy, great to see you. Thank you for your hard work.

Mr. KENNEDY OF MASSACHUSETTS. Well, thank you, Representative Tonko. You in New York passed the parity in New York. We acknowledge that.

I would say that we have to see the forest for the trees. And the forest says that if we employ a whole new system, instead of the emergency rooms, instead of the jails, we could give better care to people and it will cost us less money. And talk about a bipartisan plan that would get through Congress. So we need to talk about with GAO and OMB new mechanisms to think about mental health in a systemic way so that we are not trimming along the edges, because right now, Representative Murphy's statement that we are fiddling while Rome burns is true. We need to look at the more fundamental issues of where the funding is coming overall, and align them in between committees of jurisdiction, because a lot of people hear about the housing issues which need to be supported, the Department of Labor issues, the job training and support, none of that is aligned in our budgets and that is what hobbles our ability to have a comprehensive solution to this challenge.

Mr. TONKO. Thank you very much. Dr. Lieberman?

Dr. LIEBERMAN. I completely agree. I think it is not a matter of reducing funding, but it is a matter of—I think SAMHSA needs to be basically rehabilitated, and there is a mechanism in this bill

which really elevates the stature and importance of mental health care which had been under the rubric of SAMHSA. I remember, my career goes back to when there was ADAMHA which was the combination of the NIMH and what is now SAMHSA, and there was effective oversight and direction then, but for a variety of reasons I don't claim to be privy to, they were separated. The NIMH went back into the NIH, and SAMHSA went off on its own, and it has been a complete waste ever since.

Mr. PITTS. The gentleman's time has expired.

The chair now recognizes Mr. Loebsack 5 minutes for questions.

Mr. LOEBSACK. Thank you, Mr. Chair and Ranking Member. Thank you for letting me be an interloper here today. I am not a member of this subcommittee, and so it is a great opportunity for me to speak to some of these issues, and ask a couple of questions.

First thing I should say, as so many of the folks in this body, I have personal experience with this issue. My mom, as I was growing up, and as long as I can remember, as long as she lived, she struggled with mental illness. That leads me to the issue of stigma, and I am really glad that Ms. Schakowsky talked about that. I know that you folks are very aware of that. And, Congressman Kennedy, I mean we have talked about this while you were here, and you have been such a great champion on these issues. When I was on the Education and Labor Committee, we had a lengthy hearing, we had Rosalynn Carter come in and talk about this. I tell people often as a Member of Congress, if I don't succeed at anything else on the mental illness front, I am going to be very successful in talking about this issue and doing everything I can to remove the stigma from this issue and those folks who are struggling with this issue. And if that is all I succeed then I will have at least done something while I am here.

On the policy front, I do thank my friend, Congressman Murphy, for his attempts to do what he can on this front. I know we can do better. He knows we can do better. And I have talked to him at great length about how we can hopefully work together to resolve some of these issues.

My big issue today that I just want to mention briefly has to do with children, has to do with rural areas, and there are a number of us on this panel who are from rural areas. Clearly, children are best served by providers that are trained to meet their needs. There is no question about that. That may mean a child psychiatrist where one is available, and that is the big issue in many ways, but it should also involve pediatricians, I would argue, that have well-established relationships with families and that serve as a medical home for children. But in Iowa, there are only 53 child and adolescent psychiatrists. Now, we only have 3 million people, but only 53. And these providers are concentrated in 14 counties. That leaves 85 more rural counties without a single provider. Also, the provider on average is 52 years old. So the demographics are there as well. You know this very well, Dr. Lieberman.

I am going to be introducing legislation soon that would tackle this issue by supporting innovative programs that operate in more than ½ of all states, including my own, Iowa, to provide mental health consultation by child psychiatrists, or pediatric primary care practices, often called child psychiatry access programs, to enable

the pediatrician to treat a child in his or her office, or refer to a specialist if that is necessary. These programs, I think, show a lot of promise. They are being well received by pediatricians and by child psychiatrists alike. So I guess I would like to—Mr. Gionfriddo, and perhaps Dr. Lieberman as well, and anyone else, talk to me about these issues if you would, about the need for early childhood intervention and treatment programs, and about how the needs of children are different than the needs of adults, and how child psychiatrists are uniquely qualified, if you will, to help this population, and integrating that as well, as I have suggested.

Mr. GIONFRIDDO. Well, starting from a nonclinical perspective, and mostly sort of a parental perspective about this——

Mr. LOEBSACK. That is important.

Mr. GIONFRIDDO [continuing]. It was absolutely essential that my son, at a relatively early age, had access to a good child psychiatrist. He had access to a good child psychologist as well, and they together really helped develop a plan. Now, it didn't work out all that well because we couldn't integrate what the schools were doing, and that is a whole other issue we all need to talk about——

Mr. LOEBSACK. Right.

Mr. GIONFRIDDO [continuing]. How we do that with kids. But it is absolutely essential that we get those perspectives working with parents and the parents' pediatricians, as you point out, right from the start, because together, all of those four parties, if you will, and the social workers who assist, and others too, can put together the kind of plans that can change trajectories of lives. And that is what we have to think about here. We don't just have these two populations, all these people are going to get better on their own, or those other people we have to wait until disaster occurs to treat, 99.9 percent of the people like my son, somewhere in the vast middle of this, and we can do so much for them if we all work together, just like you are going to do so much for us by all working together this year.

Mr. LOEBSACK. That is right. Hey, we have done some of that on this committee already, and I think we have already set some good examples.

Yes, Dr. Lieberman?

Dr. LIEBERMAN. I couldn't agree with you more. If you talk to any primary care doctor, whether it is a pediatrician, a family medicine doctor, or an internist, they will tell you that 40 percent of their practice or more is psychiatric. And there aren't enough child psychiatrists, there aren't enough adult psychiatrists, to go around, and we need to have really teams of mental health care providers which include all the disciplines—psychology, social work, nurse practitioners—that have defined roles and responsibilities. But the frontier, the line of first defense, needs to be in the primary care system.

Mr. LOEBSACK. OK.

Dr. LIEBERMAN. And so mental health education needs to be part of all the primary care system. That includes pediatrics, OB/GYN, and family medicine.

Mr. KENNEDY OF MASSACHUSETTS. And I would just add collaborative care models have been validated through 80-plus randomized control trials. So this notion of building this has been dem-

onstrated to be cost-effective in outcomes, and why we don't have insurance companies reimbursing for something that is in their self-interest in terms of better financial interest and better health, is something we still have to work on. But you are right on target with trying to bridge this gap in the workforce shortage by having more collaborative care models.

Mr. LOEBSACK. Thanks to all of you. And thank you, Mr. Chair. Thank you.

Mr. PITTS. The chair thanks the gentleman.

I now recognize the gentleman from Indiana, Dr. Bucshon, 5 minutes for questions.

Mr. BUCSHON. Mr. Chairman, I yield my time to Mr. Murphy from Pennsylvania.

Mr. MURPHY. I thank the gentleman from Indiana. And just a couple of quick questions here.

Dr. Lieberman, is there anything we can do to really totally prevent schizophrenia and bipolar right now?

Dr. LIEBERMAN. I think that these conditions are preventable in the sense that we can't cure them, but we can stop them from starting. And the way to do that has really already been—a template has been created in the area of cardiovascular disease. In 1955, President Eisenhower had a heart attack and, I think it is known that he loved to play golf, he was a chain-smoker, he was obviously in high stress, he had a heart attack. And he went in the hospital for 4 weeks, he rested, afterwards they told him to take it easy for another 4, 6 weeks and then come back to work. And he sort of resumed the same lifestyle, and some years later, from a recurrent heart attack, he died. But that stimulated public attention and galvanized research in the medical community and the NIH funding. And 50 years later, the morbidity and mortality of cardiovascular—arteriosclerotic heart disease is 60 percent less, 60 percent less. But apart from that, it transformed the way cardiovascular disease was managed. It is no longer wait until somebody gets sick and then put them in the hospital or treat them with something, it is when you are born, you know what risk factors you have. You may have a family history. As you grow, you have to watch your weight. Your family may want you to watch your diet. You can have your cholesterol measured. There are now gene panels that assess risk for cardiovascular disease. So preemptively, these are being addressed. But if you do get into a point where you are short of breath and you have chests pain or something, you can have a thallium scan, you can have a stress EKG, you can have various tests with pre-morbidly, that is your secondary prevention——

Mr. MURPHY. Are we getting to some of those, so one comment Mr. Rosenthal said by fostering a sharp swing to a more medical biological approach to mental health, we shouldn't be doing that necessarily, but I mean—but yet last summer they identified 108 genetic—genomic markers of schizophrenia. I see that as a breakthrough. I hope we can get there to do these things.

And let me give a couple of concluding comments. I think I am the last person to question here.

Senator, I feel like I have made a new friend today, and I thank you for that. I thank you for your courage and your tenacity as

well. If every state had someone like you for our Nation, more people like you, we would get this done. Patrick, also a dear friend, thank you for your voice on these issues. It is powerful. We have to keep that up. Keep it motivated. Jeff Lieberman, I know you are dedicated to these things. You are a great voice in saying we can solve these problems, and we will do that. Paul, we developed a good friendship over this too, and understand we have common grounds here. We have to work on these prevention issues. It is your work that made substantial changes in this bill. I thank you for that. We will keep working on that. And, Mr. Coe and Ms. Billingsley and Rosenthal, as I said earlier, there is a lot you said I totally agree with, and what we have to do is find the right wording to make sure we have that in there. You have heard a joint commitment here as we go through with Ms. Matsui, Mr. Tonko, and others here. We have more conversations of this on the floor than—of course, the media would never report, but you know what, we are actually working together. And maybe that is the news. But because we have been so involved in mental health for a long time, I began some 40 years ago at this too, but I think of that when we are all fresh and wet behind the ears, dealing with the mental health field. One of the things that oftentimes struck me is why do we do it this way? Why can't we just help these families? Why can't we just talk to people? Why can't we use evidence-based care? And oftentimes we were told, well, we can't do it that way because, and it shouldn't be that way. I say psychiatry and psychology are the only areas of medicine that are defined by lawyers, and we need to make then defined by the patients' needs, by the consumers' needs, and get involved in a model that says really, yes, we can, and not only yes, we can, but we have to.

Now, with regard to funding on these things, look, I am first in line to nag the Appropriations Committee. And now, the Senate may have some different rules they can follow, but we have to put a bill through that is budget-neutral. We are working hard to find some offsets on this. I look forward to working with my colleagues on this. I—look, I have no doubt that this equal, equal passion for changing these things, and we will do these things together.

And I ask along those lines if all the members of this panel, all the witnesses, all the members of this subcommittee and others, we will keep working together. You have given us some great ideas today about what we have to do about the wording for this. But for all those people who we have lost this year and lost in other years, let's not make their lives lost a lost cause. Let's join together and recognize that we have to make sure that those disappearance of their lives shouldn't be a disappearance of our passion and our dedication to this. We can make this happen. I fear greatly for this Nation if we do not make this the year that we make these significant and substantial reforms in this. Let's use our voices together. We will not be silenced. We will make some changes here.

And with that, Mr. Chairman, I thank you for your leadership in this as well. We can get this done. Hopefully, next time we get together will be for a Markup, or as a group, but with my colleagues, we will work together on some wording of these things for their concerns.

And I—with that, I yield back.

Mr. PITTS. The chair thanks Dr. Murphy. Thank you for that excellent summary of our hearing today.

And the chair would like to thank all of the witnesses for your patience, for your testimony, your expertise. It has been a very important hearing in this whole path that we are traveling on this issue, and the committee will act on this legislation.

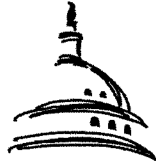
Members who were not here will have questions, I am sure. Some of us may have follow-up questions. We will submit those to you in writing. We ask that you please respond promptly.

I remind members that they have 10 business days to submit questions for the record. That means they should submit their questions by the close of business on Tuesday, June 30.

Without objection, the subcommittee is adjourned.

[Whereupon, at 12:48 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]



Congressional Research Service
Informing the legislative debate since 1914

MEMORANDUM June 15, 2015

Subject: How the Helping Families in Mental Health Crisis Act of 2015 (H.R. 2646) would change the current law abortion provision as provided in the Garrett Lee Smith Memorial Act

From: Erin Bagalman, Analyst in Health Policy (ebagalman@crs.loc.gov, 7-5345)

This memorandum was prepared to enable distribution to more than one congressional office.

This memorandum summarizes how the Helping Families in Mental Health Crisis Act of 2015 (H.R. 2646, as introduced on June 4, 2015) would change an existing restriction on the use of grant funds to pay for abortion, as provided under the Garrett Lee Smith (GLS) Memorial Act (P.L. 108-355). The existing GLS abortion restriction applies to four suicide prevention grant programs in current law (one of which has never been funded). The Helping Families in Mental Health Crisis Act of 2015 (H.R. 2646) would (among other things) reauthorize the GLS Memorial Act and in so doing would replace the abortion restriction with new language. Under H.R. 2646, the GLS abortion restriction would refer to only one suicide prevention grant program (which would also be amended by the bill) and would add a new reference to an existing homelessness formula grant program (which is not currently subject to the GLS abortion restriction).

Current Law

The GLS Memorial Act amended Section 520E of the Public Health Service Act (PHSA) to (among other things) include the following language in subsection (i): "Funds appropriated to carry out this section, section 520C, section 520E–1, or section 520E–2 shall not be used to pay for or refer for abortion." This language is codified at 42 U.S.C. Section 290bb–36(i). **Table 1** summarizes the sections of the PHSA that are subject to the existing GLS abortion restriction.

Table 1. Sections of Current Law Referenced in the GLS Memorial Act Abortion Provision

PHSA	42 U.S.C.	Title and Description
520E	290bb–36	**Youth suicide early intervention and prevention strategies.** This section requires the Secretary of Health and Human Services (HHS), acting through the Administrator of the Substance Abuse and Mental Health Services Administration (SAMHSA), to award grants or cooperative agreements for statewide or tribal strategies targeting suicide among youth. This is commonly known as GLS – State Grants.

PHSA	42 U.S.C.	Title and Description
520C	290bb–34	**Youth interagency research, training, and technical assistance centers.** This section requires the HHS Secretary, acting through the SAMHSA Administrator and in consultation with the Administrator of the Office of Juvenile Justice and Delinquency Prevention, the Director of the Bureau of Justice Assistance, and the Director of the National Institutes of Health, to award grants or contracts for up to four centers with specified responsibilities and an additional center with separately specified responsibilities. This is commonly known as GLS – Suicide Prevention Resource Center.
520E–1	290bb–36a	**Suicide prevention for youth.**[a] This section requires the HHS Secretary to award grants or cooperative agreements "to design early intervention and prevention strategies that will complement the State-sponsored statewide or tribal youth suicide early intervention and prevention strategies developed pursuant to section 520E [290bb–36]." This program has never been funded.
520E–2	290bb–36b	**Mental and behavioral health services on campus.** This section authorizes the HHS Secretary, acting through the Director of SAMHSA's Center for Mental Health Services and in consultation with the Secretary of Education, to award grants to institutions of higher education to address problems "such as depression, substance abuse, and suicide attempts." This is commonly known as GLS – Campus Grants.

Source: CRS summary of relevant provisions in the Public Health Service Act (PHSA) and United States Code (U.S.C.).

a. This heading appears as "Suicide Prevention for Children and Adolescents" in the PHSA, which includes a footnote indicating that the "probable intent" of Congress was to replace "Children and Adolescents" with "Youth" here.

H.R. 2646

The Helping Families in Mental Health Crisis Act of 2015 (H.R. 2646), Section 208(c)(2) would replace PHSA Section 520E with new language that would read (in pertinent part) as follows: "Funds appropriated to carry out this section, section 527, or section 529 shall not be used to pay for or refer for abortion." **Table 2** summarizes the sections of the PHSA that would be subject to the restriction if H.R. 2646 were enacted.

Table 2. Sections of Current Law Referenced in the H.R. 2646 Abortion Provision

PHSA	42 U.S.C.	Title and Description
520E	290bb–36	**Youth suicide early intervention and prevention strategies.** This section (as it would be amended by H.R. 2646) would require the HHS Secretary, acting through the Assistant Secretary for Mental Health and Substance Use Disorders (as would be established by H.R. 2646), to award grants or cooperative agreements for statewide or tribal strategies targeting suicide among youth, as well as related activities.
527	290cc–27	**Description of intended expenditures of grant.** This section refers to the Projects for Assistance in Transition from Homelessness (PATH) grants program under PHSA Title V, Part C (42 U.S.C. §290cc-21 – §290cc-35). PATH is a formula grant program that distributes funds to states (including the 50 states, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, American Samoa, and the Northern Mariana Islands) to support local organizations providing services for people with serious mental illness (including those with co-occurring substance use disorders) who are homeless or at imminent risk of becoming homeless.
529	290cc–29	**Requirement of application.** This section specifies the application requirements for the PATH formula grants described above.

Source: CRS summary of relevant provisions in the Public Health Service Act (PHSA), the United States Code (U.S.C.), and H.R. 2646.

The American Round Table To Abolish Homelessness

Statement for the Record

Philip F. Mangano
President
American Round Table to Abolish Homelessness

Committee on Energy and Commerce
Subcommittee on Health

June 16, 2015

"Examining H.R. 2646, the Helping Families in Mental Health Crisis Act."

The American Round Table is pleased to provide this Statement for the Record to the Committee on Energy and Commerce, Subcommittee on Health on the occasion of the hearing on H.R. 2646, the *Helping Families in Mental Health Crisis Act*, introduced by Representatives Tim Murphy (PA) and Eddie Bernice Johnson (TX).

During the 113th Congress, the Health Subcommittee and the Oversight and Investigations Subcommittee undertook important investigative work on the issue of serious mental illness in hearings and other settings. The proposed legislation [H.R. 3717] that resulted contained important new provisions but lacked needed recognition of the issue of homelessness.

The Round Table engaged Chairman Murphy and his staff and other Committee members to remedy this gap. Chairman Murphy heard our concerns and revised the new bill to be more reflective of the needs of our most vulnerable and most disabled neighbors who are mentally ill and living in shelters and languishing on the streets of our country. This more specific reach into the lives of people who are homeless and proposals to increase their access to evidence-based treatment – as well as recognition of their need for targeted and comprehensive services - will ensure that crucial mental health resources are focused on those most in need of them. ~more

Ensuring that mental health services are targeted to homeless people will provide needed resources for those who engage the most disabled in their most extreme circumstances. The American Round Table to Abolish Homelessness affirms that the new iteration of the bill is far more responsive and sensitive to the needs of our poorest and most disabled citizens.

The American Round Table to Abolish Homelessness works with communities across the country to upgrade their response in ending homelessness, specifically working with elected and appointed officials, provider agencies, and, most importantly, consumers.

The Round Table is committed to strategies to end homelessness that are research and data driven, performance-based, consumer-centric, and results-oriented and to the rapid dissemination of innovation, information, and inspiration to our partners. Our work is governed by the single metric of ending homelessness, especially the long-term homelessness of our most vulnerable and disabled neighbors living on the streets and languishing in shelters. We are committed to the philosophy and practice of a sense of belonging in the community for people who have experienced homelessness.

Cost studies across the nation have established that the chronically homeless population is at highest risk of death and is most costly to the public purse in its use of public and private services in health care, emergency response, local police and jails, and behavioral health.

The Round Table seeks to scale "what works" to end homelessness, and we endeavor to identify "Next Practices" that are future-focused and represent the next generation of innovations to end homelessness. The proposed adoption of a federal standard of evidence-based practices for treatment in this legislation is an important step forward and will advance the established use of Housing First and CTI for people who are homeless. We believe that identifying future focused Next Practices is important in advancing new strategies and technologies that achieve results.

H.R. 2646, the Helping Families in Mental Health Crisis Act, provides much needed and increased visibility to people who are homeless and living with mental illness, focuses on data and outcomes that have been crucial in achieving results in ending homelessness, emphasizes effectiveness in targeting and reaching homeless people, and underscores the fundamental goal of reducing homelessness.

Recent national data on homelessness collected in local communities demonstrates the importance of this legislation for individuals who are homeless and living with serious mental illness. Of the 13 percent of people who experience long-term or chronic homelessness – individuals who have been the focus of the Federal goal to end chronic homelessness ~more

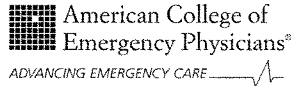
since 2002 -more than 80 percent struggle with some combination of mental illness, addiction, and major medical ailments.

Access to treatment and the central antidote to homelessness of permanent housing - in the form of the cost-effective and evidence based innovation of Housing First - are the solution to end homelessness and create a trajectory of recovery.

We support efforts to expand the provision of evidence-based mental health services necessary for the well-being of individuals with serious mental illness who receive treatment through the community mental health system, an integrated behavioral health and primary care network, or an in-patient setting. We also support the use of Assisted Outpatient Treatment which has been shown to reduce homelessness, end the random ricocheting of individuals through expensive crisis systems, and reduce costs to the taxpayer in the use of acute and emergency services, including law enforcement.

Comprehensive mental health reforms, such as those proposed, deserve attention by a broad range of stakeholders. All will be important for our most vulnerable neighbors in seeking stability, an end to their homelessness, and a future of recovery and integration in the community. Each element focused on homelessness will improve the service delivery system and advance treatment and recovery. The use of peers in service delivery and the recognition of the role of increased rates of employment and enrollment in educational and vocational programs are key to promoting recovery and a life in the community.

The Round Table is committed to working with mental health leaders in Congress to forward this bill. Access to treatment and the central antidote to homelessness of permanent housing - in the form of the cost-effective and evidence- based innovation of Housing First - are the solution to end homelessness and create a trajectory of recovery.



June 11, 2015

The Honorable Tim Murphy
2332 RHOB
Washington, DC 20515

Dear Congressman Murphy:

On behalf of the American College of Emergency Physicians (ACEP) and our 33,000 members, I am writing to express ACEP's support for H.R. 2646, the "Helping Families in Mental Health Crisis Act of 2015," and to thank you for your leadership on this important issue.

For years, state support for mental health resources has been on the decline. As a consequence, services for psychiatric patients in the United States are simply inadequate. As a result of this diminishing support, psychiatric patients are more and more often turning to emergency departments for their acute care needs. Unfortunately, it takes three times as long to find an inpatient bed for a psychiatric patient rather than a medical patient after the decision to admit has been made. These psychiatric patients require more physician, nurse and hospital resources than other patients and, thus, diminish our ability to evaluate and treat other medical patients who are awaiting emergency services.

ACEP actively supports your efforts to improve access to vitally needed inpatient psychiatric beds and community mental health services. Your legislation will improve research, data collection and efficacy of existing mental health programs, promote evidence-based medicine to create systems of care for patients with mental illness, and encourage early intervention and prevention programs. Additionally, H.R. 2646 will remove regulations that currently prohibit the same-day billing under Medicaid for treatment of physical and mental health for the same patient, in the same location, on the same day; ameliorate the Medicaid Institutes for Mental Disease (IMD) exclusion by giving states the option to receive federal matching payments for care of adult patients with mental illness; and establish federal liability protections for health professionals who volunteer at community health centers or behavioral health centers.

We look forward to working with you and your congressional colleagues to achieve swift committee approval of this critical, bi-partisan legislation and its enactment into law.

Sincerely,

Michael J. Gerardi, MD, FAAP, FACEP
President, ACEP

WASHINGTON, DC OFFICE
2121 K Street NW, Suite 325
Washington, DC 20037-1886

202-728-0610
800-320-0610
202-728-0617 (FAX)
www.acep.org

BOARD OF DIRECTORS
Michael J. Gerardi, MD, FACEP
President
Jay A. Kaplan, MD, FACEP
President-Elect
Rebecca B. Parker, MD, FACEP
Chair of the Board
Paul D. Kivela, MD, FACEP
Vice President
John J. Rogers, MD, CPE, FACEP
Secretary-Treasurer
Alexander M. Rosenau, DO, CPE, FACEP
Immediate Past President
Stephen H. Anderson, MD, FACEP
James J. Augustine, MD, FACEP
Vidor E. Friedman, MD, FACEP
Jon Mark Hirshon, MD, PhD, MPH, FACEP
Hans R. House, MD, FACEP
William P. Jaquis, MD, FACEP
Robert E. O'Connor, MD, MPH, FACEP
Debra G. Perina, MD, FACEP

COUNCIL OFFICERS
Kevin M. Klauer, DO, EJD, FACEP
Speaker
James M. Cusick, MD, FACEP
Vice Speaker

EXECUTIVE DIRECTOR
Dean Wilkerson, JD, MBA, CAE

NATIONAL COUNCIL
FOR BEHAVIORAL HEALTH
STATE ASSOCIATIONS OF ADDICTION SERVICES
Stronger Together.

June 5, 2015

The Honorable Tim Murphy
2332 Rayburn House Office Building
United States House of Representatives
Washington, DC 20515

The Honorable Eddie Bernice Johnson
2468 Rayburn House Office Building
United States House of Representatives
Washington, DC 20515

Dear Representatives Murphy and Johnson:

On behalf of the National Council for Behavioral Health, I am writing to express our gratitude for your continued focus on raising the national profile of important mental health and addiction treatment issues. Your legislation, the Helping Families in Mental Health Crisis Act (H.R. 2646) includes many important provisions that will support mental health and addiction treatment providers and the individuals they serve.

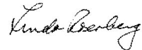
In particular, we applaud your inclusion of Section 701, based on the Behavioral Health Information Technology Act, the legislation you have tirelessly championed over several sessions of Congress. Extending federal health IT incentive payments to mental health and addiction treatment providers will go a long way toward helping our nation's health care providers offer high-quality, fully coordinated services.

We are also grateful for your inclusion of Section 505, which extends the bipartisan Excellence in Mental Health Act demonstration program by two years and two states. This extension to the demonstration program will make an enormous contribution to expanding access to evidence-based community healthcare for children and adults with serious and persistent mental illnesses. It will support states and providers in reducing high hospital emergency room utilization among persons living with behavioral health conditions while easing the burden on hard-pressed law enforcement agencies in urban and rural areas. Perhaps most importantly, the Excellence Act demonstration will assist the Veterans Administration (VA) with serving the young men and women returning from Iraq and Afghanistan with service connected mental disorders including clinical depression and PTSD.

In addition, we thank you for the inclusion of several long-sought priorities in your legislation, such as clarifying that providers may bill Medicaid for mental and physical health services provided on the same day; codifying the Medicare Six Protected Classes policy; strengthening parity enforcement; modifying inpatient psychiatric hospital discharge planning to ensure better coordination with outpatient providers, authorizing grants for crisis intervention trainings for law enforcement officers, and authorizing grants for mental health education and awareness in educational settings.

We welcome this opportunity to continue our nation's dialogue around the pressing issues of improving access to mental health and addiction care. We look forward to working with you and the diverse stakeholders in the behavioral health field to advance legislation that will save lives and improve health outcomes.

Sincerely,



Linda Rosenberg, MSW
President and CEO
National Council for Behavioral Health

National Alliance on Mental Illness

June 15, 2015

The Honorable Tim Murphy
The Honorable Eddie Bernice Johnson
U.S. House of Representatives
Washington, DC 20515

Dear Representatives Murphy & Johnson:

On behalf of the National Alliance on Mental Illness (NAMI), I am writing to express our thanks and support for your leadership in bringing forward reintroduction of the Helping Families in Mental Health Crisis Act (HR 2646) in the 114th Congress. We are extremely grateful for your efforts to support comprehensive legislation to improve mental health treatment, services and supports across the United States.

NAMI is the nation's largest organization representing children and adults living with mental illness and their families. In hundreds of communities throughout the nation, NAMI is engaged in education, support, public awareness and advocacy to improve the lives of people affected by mental illness and their families so they can achieve recovery, resiliency and wellness.

NAMI is pleased that HR 2646 includes a range of reforms that would improve our nation's failing public mental health system including efforts to focus on outcomes, break down barriers for consumers and families to access treatment, and expand the availability of evidence-based practices.

We are particularly appreciative of provisions in your legislation that will expand efforts to ensure full implementation and enforcement of the Mental Health Parity and Addiction Equity (MHPAEA). Your legislation would also improve integration and program coordination across multiple federal agencies that serve people living with serious mental illness and remove discriminatory impediments to mental healthcare. HR 2646 also contains provisions designed to facilitate the integration of mental health and physical health care in Medicaid, spur early intervention in the treatment of psychosis, improve the use of health information technology in mental health care, remove discriminatory barriers in acute inpatient treatment in Medicaid and Medicare, and provide resources for suicide prevention.

NAMI thanks you once again for your leadership and tireless efforts on behalf of people affected by the most serious mental illnesses and their families. We believe that the goals of improving mental health treatment and services and promoting recovery and autonomy are compatible. We look forward to working with you to strengthen the role of consumers and families in federal oversight and on advocacy for recovery based services and supports.

Sincerely,

Mary Giliberti, J.D.
Executive Director

NAMI • 3803 North Fairfax Drive, Suite 100 • Arlington, VA 22203-1701
(703) 524-7600 • www.nami.org

AMERICAN
PSYCHOLOGICAL
ASSOCIATION

AMERICAN
PSYCHOLOGICAL
ASSOCIATION
PRACTICE ORGANIZATION

June 15, 2015

The Honorable Tim Murphy
2332 Rayburn House Office Building
United States House of Representatives
Washington, DC 20515

The Honorable Eddie Bernice Johnson
2468 Rayburn House Office Building
United States House of Representatives
Washington, DC 20515

Dear Representatives Murphy and Johnson:

On behalf of the American Psychological Association (APA) and American Psychological Association Practice Organization (APAPO), we are writing to express our appreciation and support for the "Helping Families in Mental Health Crisis Act of 2015" (H.R. 2646). This comprehensive legislation offers major structural improvements to our nation's mental health system, in order to help individuals with serious mental illness and their families.

The APA is the largest scientific and professional organization representing psychology in the United States and the world's largest association of psychologists, with more than 122,500 researchers, educators, clinicians, consultants, and students. The APAPO is a companion organization to the APA, and is dedicated to advancing the practice of psychology and promoting the interests of psychologists who practice in diverse settings.

H.R. 2646 includes many notable provisions that will improve access to effective care, particularly for individuals with the most severe mental disorders. These provisions include increasing emphasis on evidence-based mental health services, expanding authority for mental health services financed by Medicaid, and eliminating the long-standing discriminatory 190-day lifetime limit in Medicare for psychiatric hospital services. Furthermore, we thank you for reauthorizing the Garrett Lee Smith Memorial Act and the National Child Traumatic Stress Network, as well as explicitly authorizing the Minority Fellowship Program and the National Suicide Prevention Lifeline program. We also share your vision of elevating the federal government's responsibility in the coordination of mental health funding across programs.

We applaud your commitment to ensuring that psychologists and other mental and behavioral health providers and facilities receive Medicaid and Medicare incentives to adopt electronic health records. This will aid in coordinating and integrating care for vulnerable patients, as included in Title VII (Behavioral Health Information Technology) of the bill. Achieving integration of mental health into primary care will be hampered as long as electronic health record systems do not enable mental health providers to communicate with medical/surgical providers. We also appreciate support for research at the National Institute of Mental Health addressing the risk factors for, and prevention of, suicide and violence among those with mental illness, as well as advancing our understanding of the workings of the human brain.

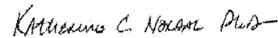
750 First Street, NE
Washington, DC 20002-4242
(202) 336-5800
(202) 336-6123 TDD

E-mail: practice@apa.org
Web: www.apa.org

Additionally, we are also very pleased that the reintroduced bill attends to the need for full compliance and enforcement of the Mental Health Parity and Addiction Equity Act of 2008. The mental health community was united in the passage of this historic law, and it is long past time for patients to realize the end of health insurance discrimination for mental health and substance abuse coverage.

We are grateful for your leadership and value having your combined clinical expertise, as a practicing psychologist and psychiatric nurse, respectively, at the helm of these important reforms. We look forward to working with you, your staff, and colleagues to further improve and advance the bill through the legislative process.

Sincerely,



Norman B. Anderson, Ph.D.
Chief Executive Officer

Katherine C. Nordal, Ph.D.
Executive Director for Professional Practice

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

WWW.AACAP.ORG

Council

President
Paramjit T. Joshi, M.D.

President-Elect
Gregory K. Fritz, M.D.

Secretary
Aradhana "Bela" Sood, M.D.

Treasurer
David G. Fassler, M.D.

Chair, Assembly
of Regional Organizations
of Child and Adolescent Psychiatry
Warren Y.K. Ng, M.D.

Past President
Martin J. Drell, M.D.

Mark S. Borer, M.D.
Stephen J. Cozza, M.D.
Deborah Deas, M.D.
Debra E. Koss, M.D.
Joan Luby, M.D.
Kaye L. McGinty, M.D.
Kayla Pope, M.D.
Neal Ryan, M.D.
Jennifer S. Saul, M.D.
Harsh K. Trivedi, M.D.

Jerry M. Wiener
Resident Member
Vandai X. Le, M.D.

John E. Schowalter
Resident Member
Marika Wrzosek, M.D.

Executive Director
Heidi B. Fordi, CAE

Journal Editor
Andrés Martin, M.D.

AACAP News Editor
Uma Rao, M.D.

Program Committee Chair
Gabrielle A. Carlson, M.D.

Robert L. Stubblefield
Resident Fellow to AMA HOD
Anita Chu, M.D.

Honorable Tim Murphy
2332 Rayburn House Office Building
Washington, DC, 20515

Honorable Eddie Bernice Johnson
2467 Rayburn House Office Building
Washington, DC, 20515

June 9, 2015

Dear Chairman Murphy and Congresswoman Johnson:

On behalf of the nearly 9,000 physician members of the American Association of Child and Adolescent Psychiatry (AACAP), I write in strong support of the significantly strengthened H.R. 2646, the "Helping Families in Mental Health Crisis Act of 2015." Your vision for comprehensive mental health reform is very clear, and the needs are urgent. Together, we must act quickly to bring new focus and efficiency to government programs and advance policy refinements that will deliver scarce resources to those most in need of mental health services.

To that end, we reaffirm our commitment to achieving your proposed creation of the position of Assistant Secretary for Mental Health and Substance Abuse Disorders within the Department of Health and Human Services. We are greatly heartened that he or she will focus on many new and important programmatic duties, including "increased access to child and adolescent psychiatry services in order to provide early intervention for prevention and mitigation of mental illness."

We also note with great approval that other revamped grant programs in the bill would focus spending on serious mental illness (SMI) and serious emotional disturbance (SED), with an added emphasis to "collaborate with other child-serving systems such as child welfare, education, juvenile justice, and primary care systems." Mental health services for children and adolescents will receive vital new support through your bill.

AACAP is also extremely grateful for the bill's language in Section 207 WORKFORCE DEVELOPMENT at subsection (d) that will sensibly extend the National Health Service Corps loan relief program to child and adolescent psychiatry trainees and their training programs. Through your strong efforts, we will begin to alleviate the extreme shortage of child and adolescent psychiatrists. Thank you for the special privilege of allowing our staff to work with both of you in the drafting of this key provision.

We also particularly applaud the proposed Section 202 INNOVATION GRANTS, whereby

3615 Wisconsin Avenue, NW | Washington, DC 20016-3007 | 202.966.7300 | www.aacap.org

not less than 1/3 of the grant money would flow to screening, diagnosis, treatment or services to those under 18 years of age. Similarly, under Section 203 DEMONSTRATION GRANTS, not less than half of the money would flow to those under 26 years of age, with added eligibility for screening, diagnosis, intervention, and treatment.

These sections are then followed by Section 204 EARLY CHILDHOOD INTERVENTION AND TREATMENT, whereby the proposed National Mental Health Policy Laboratory would focus on "eligible child," ages 0 to 12. Together, these key sections are highly congruent with AACAP policy and would ensure important new resources to those most in need of treatment and services, especially the most vulnerable and needful of our children.

We note with added approval that venerable and highly successful programs such as Garrett Lee Smith Suicide Prevention Program and the National Child Traumatic Stress Network are reauthorized under your bill. In addition, the bill appropriately demands greater accountability and enforcement of mental health parity laws.

We remain extremely gratified to be able to provide our expert counsel on child and adolescent psychiatry and deeply value the confidence you have placed in AACAP as a trusted partner in moving this new bill forward.

Sincerely,

Paramjit T. Joshi, MD
President

The Washington Post

National

Fatal police shootings in 2015 approaching 400 nationwide

By Kimberly Kindy, and reported by Julie Tate, Jennifer Jenkins, Steven Rich, Keith L. Alexander and Wesley Lowery May 30

In an alley in Denver, police gunned down a 17-year-old girl joyriding in a stolen car. In the backwoods of North Carolina, police opened fire on a gun-wielding moonshiner. And in a high-rise apartment in Birmingham, Ala., police shot an elderly man after his son asked them to make sure he was okay. Douglas Harris, 77, answered the door with a gun.

The three are among at least 385 people shot and killed by police nationwide during the first five months of this year, more than two a day, according to a Washington Post analysis. That is more than twice the rate of fatal police shootings tallied by the federal government over the past decade, a count that officials concede is incomplete.

"These shootings are grossly underreported," said Jim Bueermann, a former police chief and president of the Washington-based Police Foundation, a nonprofit organization dedicated to improving law enforcement. "We are never going to reduce the number of police shootings if we don't begin to accurately track this information."

Ad

A national debate is raging about police use of deadly force, especially against minorities. To understand why and how often these shootings occur, The Washington Post is compiling a database of every fatal shooting by police in 2015, as well as of every officer killed by gunfire in the line of duty. The Post looked exclusively at shootings, not killings by other means, such as stun guns and deaths in police custody.

Using interviews, police reports, local news accounts and other sources, The Post tracked more than a dozen details about each killing through Friday, including the victim's race, whether the person was armed and the circumstances that led to the fatal encounter. The result is an unprecedented examination of these shootings, many of which began as minor incidents and suddenly escalated into violence.

Among The Post's findings:

- About half the victims were white, half minority. But the demographics shifted sharply among the unarmed victims, two-thirds of whom were black or Hispanic. Overall, blacks were killed at three times the rate of whites or other minorities when adjusting by the population of the census tracts where the shootings occurred.

•The vast majority of victims — more than 80 percent — were armed with potentially lethal objects, primarily guns, but also knives, machetes, revving vehicles and, in one case, a nail gun.

•Forty-nine people had no weapon, while the guns wielded by 13 others turned out to be toys. In all, 16 percent were either carrying a toy or were unarmed.

•The dead ranged in age from 16 to 83. Eight were children younger than 18, including Jessie Hernandez, 17, who was shot three times by Denver police officers as she and a carload of friends allegedly tried to run them down.

The Post analysis also sheds light on the situations that most commonly gave rise to fatal shootings. About half of the time, police were responding to people seeking help with domestic disturbances and other complex social situations: A homeless person behaving erratically. A boyfriend threatening violence. A son trying to kill himself.

Ninety-two victims — nearly a quarter of those killed — were identified by police or family members as mentally ill.

In Miami Gardens, Fla., Catherine Daniels called 911 when she couldn't persuade her son, Lavall Hall, a 25-year-old black man, to come in out of the cold early one morning in February. A diagnosed schizophrenic who stood 5-foot-4 and weighed barely 120 pounds, Hall was wearing boxer shorts and an undershirt and waving a broomstick when police arrived. They tried to stun him with a Taser gun and then shot him.

The other half of shootings involved non-domestic crimes, such as robberies, or the routine duties that occupy patrol officers, such as serving warrants.

Nicholas T. Thomas, a 23-year-old black man, was killed in March when police in Smyrna, Ga., tried to serve him with a warrant for failing to pay $170 in felony probation fees. Thomas fled the Goodyear tire shop where he worked as a mechanic, and police shot into his car.

Although race was a dividing line, those who died by police gunfire often had much in common. Most were poor and had a history of run-ins with law enforcement over mostly small-time crimes, sometimes because they were emotionally troubled.

Both things were true of Daniel Elrod, a 39-year-old white man. Elrod had been arrested at least 16 times over the past 15 years; he was taken into protective custody twice last year because Omaha police feared he might hurt himself.

On the day he died in February, Elrod robbed a Family Dollar store. Police said he ran when officers arrived, jumping on top of a BMW in the parking lot and yelling, "Shoot me, shoot me." Elrod, who was unarmed, was shot three times as he made a "mid-air leap" to clear a barbed-wire fence, according to police records.

Dozens of other people also died while fleeing from police, The Post analysis shows, including a significant proportion — 20 percent — of those who were unarmed. Running is such a provocative act that police experts say there is a name for the injury officers inflict on suspects afterward: a "foot tax."

Police are authorized to use deadly force only when they fear for their lives or the lives of others. So far, just three of the 385 fatal shootings have resulted in an officer being charged with a crime — less than 1 percent.

The low rate mirrors the findings of a Post investigation in April that found that of thousands of fatal police shootings over the past decade, only 54 had produced criminal charges. Typically, those cases involved layers of damning evidence challenging the officer's account. Of the cases resolved, most officers were cleared or acquitted.

In all three 2015 cases in which charges were filed, videos emerged showing the officers shooting a suspect during or after a foot chase:

•In South Carolina, police officer Michael Slager was charged with murder in the death of Walter Scott, a 50-year-old black man, who ran after a traffic stop. Slager's attorney declined to comment.

•In Oklahoma, reserve deputy Robert Bates was charged with second-degree manslaughter 10 days after he killed Eric Harris, a 44-year-old black man. Bates's attorney, Clark Brewster, characterized the shooting as a "legitimate accident," noting that Bates mistakenly grabbed his gun instead of his Taser.

•And in Pennsylvania, officer Lisa Mearkle was charged with criminal homicide six weeks after she shot and killed David Kassick, a 59-year-old white man, who refused to pull over for a traffic stop. Her attorney did not return calls for comment.

In many other cases, police agencies have determined that the shootings were justified. But many law enforcement leaders are calling for greater scrutiny.

After nearly a year of protests against police brutality and with a White House task force report calling for reforms, a dozen current and former police chiefs and other criminal justice officials said police must begin to accept responsibility for the carnage. They argue that a large number of the killings examined by The Post could be blamed on poor policing.

"We have to get beyond what is legal and start focusing on what is preventable. Most are preventable," said Ronald L. Davis, a former police chief who heads the Justice Department's Office of Community Oriented Policing Services.

Police "need to stop chasing down suspects, hopping fences and landing on top of someone with a gun," Davis said. "When they do that, they have no choice but to shoot."

As a start, criminologists say the federal government should systematically analyze police shootings. Currently, the FBI struggles to gather the most basic data. Reporting is voluntary, and since 2011, less than 3 percent of the nation's 18,000 state and local police agencies have reported fatal shootings by their officers to the FBI. As a result, FBI records over the past decade show only about 400 police shootings a year — an average of 1.1 deaths per day.

According to The Post's analysis, the daily death toll so far for 2015 is close to 2.6. At that pace, police will have shot and killed nearly 1,000 people by the end of the year.

"We have to understand the phenomena behind these fatal encounters," Bueermann said. "There is a compelling social need for this, but a lack of political will to make it happen."

For the vast majority of departments, a fatal shooting is a rare event. Only 306 agencies have recorded one so far this year, and most had only one, the Post analysis shows.

However, 19 state and local departments were involved in at least three fatal shootings. Los Angeles police lead the nation with eight. The latest occurred May 5, when Brendon Glenn, a 29-year-old homeless black man, was shot after an altercation outside a Venice bar.

Oklahoma City police have killed four people, including an 83-year-old white man wielding a machete.

"We want to do the most we can to keep from taking someone's life, even under the worst circumstances," said Oklahoma City Police Chief William Citty. "There are just going to be some shootings that are unavoidable."

In Bakersfield, Calif., all three of the department's killings occurred in a span of 10 days in March. The most recent involved Adrian Hernandez, a 22-year-old Hispanic man accused of raping his roommate, dousing her with flammable liquid and setting fire to their home.

After a manhunt, police cornered Hernandez, who jumped out of his car holding a BB gun. Police opened fire, and some Bakersfield residents say they are glad the officers did.

"I'm relieved he can't come back here, to be honest with you," said Brian Haver, who lives next door to the house Hernandez torched. "If he came out holding a gun, what were they supposed to do?"

Although law enforcement officials say many shootings are preventable, that is not always true. In dozens of cases, officers rushed into volatile situations and saved lives. Examples of police heroism abound.

In Tempe, Ariz., police rescued a 25-year-old woman who had been stabbed and tied up and was screaming for help. Her boyfriend, Matthew Metz, a 26-year-old white man, also stabbed an officer before he was shot and killed, according to police records.

In San Antonio, a patrol officer heard gunshots and rushed to the parking lot of Dad's Karaoke bar to find a man shooting into the crowd. Richard Castilleja, a 29-year-old Latino, had hit two men and was still unloading his weapon when he was shot and killed, according to police records.

And in Los Angeles County, a Hawthorne police officer working overtime was credited with saving the life of a 12-year-old boy after a frantic woman in a gray Mercedes pulled alongside the officer and said three men in a white Cadillac were following her and her son.

Seconds later, the Cadillac roared up. Robert Washington, a 37-year-old black man, jumped out and began shooting into the woman's car.

"He had two revolvers and started shooting both of them with no words spoken. He shot and killed the mom, and then he started shooting at the kid," said Eddie Aguirre, a Los Angeles County homicide detective investigating the case.

"The deputy got out of his patrol car and started shooting," Aguirre said. "He saved the boy's life."

In about half the shootings, police were responding to non-domestic criminal situations, with robberies and traffic infractions ranking among the most common offenses. Nearly half of blacks and other minorities were killed under such circumstances. So were about a third of whites.

In North Carolina, a police officer searching for clues in a hit-and-run case approached a green and white mobile home owned by Lester Brown, a 58-year-old white man. On the front porch, the officer spotted an illegal liquor still. He called for backup, and drug agents soon arrived with a search warrant.

Officers knocked on the door and asked Brown to secure his dog. Instead, Brown dashed upstairs and grabbed a Soviet SKS rifle, according to police reports.

Neighbor Joe Guffey Jr. told a local TV reporter that he was sitting at home with his dogs when the shooting started: "Pow, pow, pow, pow." Brown was hit seven times and pronounced dead at the scene.

While Brown allegedly stood his ground, many others involved in criminal activity chose to flee when confronted by police. Kassick, for example, attracted Mearkle's attention because he had expired vehicle inspection stickers. On the day he died, Kassick was on felony probation for drunken driving and had drugs in his system, police and autopsy reports show.

After failing to pull over, Kassick drove to his sister's house in Hummelstown, Pa., jumped out of the car and ran. Mearkle repeatedly struck Kassick with a stun gun and then shot him twice in the back while he was face-down in the snow.

Jimmy Ray Robinson, a.k.a. the "Honey Bun Bandit," allegedly robbed five convenience stores in Central Texas, grabbing some of the sticky pastries along the way. Robinson, a 51-year-old black man, fled when he spotted Waco police officers staking out his home.

Robinson sped off in reverse in a green Ford Explorer. It got stuck in the mud, and four Waco officers opened fire.

"They think they can outrun the officers. They don't realize how dangerous it is," said Samuel Lee Reid, executive director of the Atlanta Citizen Review Board, which investigates police shootings and recently launched a "Don't Run" campaign. "The panic sets in," and "all they can think is that they don't want to get caught and go back to jail."

The most troubling cases began with a cry for help.

About half the shootings occurred after family members, neighbors or strangers sought help from police because someone was suicidal, behaving erratically or threatening violence.

Take Shane Watkins, a 39-year-old white man, who died in his mother's driveway in Moulton, Ala.

Watkins had never been violent, and family members were not afraid for their safety when they called Lawrence County sheriff's deputies in March. But Watkins, who suffered from bipolar disorder and schizophrenia, was off his medication. Days earlier, he had declared himself the "god of the fifth element" and demanded whiskey and beer so he could "cleanse the earth with it," said his sister, Yvonne Cote.

Then he started threatening to shoot himself and his dog, Slayer. His mother called Cote, who called 911. Cote got back on the phone with her mother, who watched Watkins walk onto the driveway holding a box cutter to his chest. A patrol car pulled up, and Cote heard her mother yell: "Don't shoot! He doesn't have a gun!"

"Then I heard the gunshots," Cote said.

Lawrence County sheriff's officials declined to comment and have refused to release documents related to the case.

"There are so many unanswered questions," she said. "All he had was a box cutter. Wasn't there some other way for them to handle this?"

Catherine Daniels called police for the same reason. "I wanted to get my son help," she said. Instead, officers Peter Ehrlich and Eddo Trimino fired their stun guns after Hall hit them with the metal end of the broomstick, according to investigative documents.

"Please don't hurt my child," Daniels pleaded, in a scene captured by a camera mounted on the dash of one of the patrol cars.

"Get on the f---ing ground or you're dead!" Trimino shouted. Then he fired five shots.

Police spokesman Mike Wright declined to comment on the case. Daniels said no one from the city has contacted her. "I haven't received anything. No apology, nothing."

But hours after her son was killed, Daniels said, officers investigating the shooting dropped off a six-pack of Coca-Cola.

"I regret calling them," Daniels said. "They took my son's life."

Ted Mellnik, John Muyskens and Amy Brittain contributed to this report.

About this article

As part of an ongoing examination of police accountability, The Washington Post has attempted to track every fatal shooting by law enforcement nationwide since January, as well as the number of officers who were fatally shot in the line of duty.

The Post compiled the data using news reports, police records, open sources on the Internet and other original reporting. Several organizations, including Killed by Police and Fatal Encounters, have been collecting information about people who die during encounters with police.

The Post documented only those incidents in which a police officer, while on duty, shot and killed a civilian. Cases in which officers were shot to death were also tabulated.

To comprehensively examine the issue, a database was compiled with information about each incident, including the deceased's age, race, gender, location and general circumstances. The Post also noted whether police reported that the person was armed and, if so, with what type of weapon.

The FBI and the Centers for Disease Control and Prevention log fatal police shootings, but the data the two federal agencies gather is incomplete. The Post analyzed a decade of FBI and CDC records as part of the study.

To examine racial and economic patterns, The Post identified the location of every fatal shooting and compared it with the composition of the surrounding census tract.

The data, which will be collected through the end of the year, will be made public at a future date.

Kimberly Kindy is a government accountability reporter at The Washington Post.

Steven Rich is the database editor for investigations at The Washington Post. While at The Post, he's worked on investigations involving tax liens, civil forfeiture, cartels and government oversight. He was also a member of the reporting team awarded the Pulitzer for NSA revelations. PGP Fingerprint: 69FA 5730 ADDD 5488 24FE 6EB2 B727 D930

Keith Alexander covers crime, specifically D.C. Superior Court cases for The Washington Post. He has covered dozens of crime stories from Banita Jacks, the Washington woman charged with killing her four daughters, to the murder trial of slain federal intern Chandra Levy.

Wesley Lowery is a national reporter covering law enforcement and justice for the Washington Post. He previously covered Congress and national politics.

FRED UPTON, MICHIGAN
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED FOURTEENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–6115
Majority (202) 225-2927
Minority (202) 225-3641

July 9, 2015

Dr. Jeffrey A. Lieberman
Chairman
Department of Psychiatry
College of Physicians and Surgeons
Columbia University
1051 Riverside Drive
New York, NY 10032

Dear Dr. Lieberman:

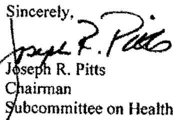
Thank you for appearing before the Subcommittee on Health on June 16, 2015, to testify at the hearing entitled "Examining H.R. 2646, the Helping Families in Mental Health Crisis Act."

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 July 23, 2015. Your responses should be mailed to Graham Pittman, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to graham.pittman@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,



Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Gene Green, Ranking Member, Subcommittee on Health

Attachment

Attachment — Additional Questions for the Record

The Honorable Representative Murphy

In a response letter to the Committee dated April 28, 2015, SAMHSA informed us that it was working to improve the rigor of its National Registry of Evidence-Based Programs and Practices and bring it into closer alignment with other registries of evidence-based programming in the federal government.

1. Why is it so important that SAMHSA, and other agencies within the U.S. Public Health Service, concentrate their efforts and resources to treat serious mental illness on the use of evidence-based practices?

In the comments on H.R. 2646 contained in his prepared testimony, Mr. Coe argues that "there is a lack of research or evaluation on the long-term use of psychotropic medications." Also, Mr. Coe suggests that since psychotropic medications do not appear on SAMHSA's registry of evidence-based programs, they must not be evidence-based.

2. Based on your professional experience, would you agree or disagree with Mr. Coe's contention that "there is a lack of research or evaluation on the long-term use of psychotropic medications"?

3. HIPAA seems to presume that patients are always competent to make informed decisions about whether or not to share information with their immediate family or caregivers. Isn't this problematic in cases where the patient is unable to recognize- or in fact vigorously denies- that they are sick?

FRED UPTON, MICHIGAN
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED FOURTEENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–6115
Majority (202) 225-2927
Minority (202) 225-3641

July 9, 2015

Mr. Harvey Rosenthal
Executive Director
New York Association of
Psychiatric Rehabilitation Services
194 Washington Avenue
Albany, NY 12210

Dear Mr. Rosenthal:

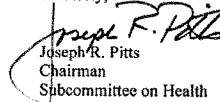
Thank you for appearing before the Subcommittee on Health on June 16, 2015, to testify at the hearing entitled "Examining H.R. 2646, the Helping Families in Mental Health Crisis Act."

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 July 23, 2015. Your responses should be mailed to Graham Pittman, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to graham.pittman@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,



Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Gene Green, Ranking Member, Subcommittee on Health

Attachment

Attachment — Additional Questions for the Record

The Honorable Representative Lujan

One area that needs more attention is how to improve access to mental health services in rural areas such as my district. Mr. Rosenthal, as you know, individuals with mental illness face unique challenges to accessing mental health treatment and support services.

1. Could you briefly describe some of those challenges?

The challenge that I want to particularly focus on is the shortage of mental health professionals in rural settings. According to the Health Resources and Services Administration (HRSA), there are 146 mental health professional shortage areas in New Mexico.

2. Could you discuss strategies for increasing the mental health workforce in rural America?

New Mexico is very diverse. According to the U.S. Census Bureau, New Mexico is 47% Hispanic and 10% Native American and Alaska Natives. Therefore, increasing the mental health workforce, including the number of professionals from racial and ethnic backgrounds is important to my constituents.

3. Are there particularly strategies that work to recruit mental health providers from racial and ethnic backgrounds?

While I support the increased emphasis on workforce issues included in this bill, I want to make sure that we identify strategies to increase that workforce in rural communities as well as to increase participation by diverse individuals. Additionally, I want to point to a concern that I have with the authorization of the Minority Fellowship Program. As you know, for the last 40 years, the Minority Fellowship Program has been encouraging individuals from diverse backgrounds to pursue careers in mental health. While I support authorizing that program, I am concerned that the proposed funding level included in the bill is $6 million, which is less than the $10.669 million the MFP received in FY 2015.

4. Can you speak to the impact that this program has had and how decreased funding will impact it?

5. Do you have any suggestions on how we could strengthen this program or other ways we can promote a diverse healthcare workforce?

In my home state of New Mexico and across the nation we are grappling with how to best equip first responders and police officers when they're called into situations where they must deal with people suffering from mental health issues. Last year, the Albuquerque Police Department made national news when two officers fatally shot a mentally ill homeless man and the community is wrestling with how to reform the system. In my district, the Santa Fe the County government is funding a program meant to help those struggling with mental health or suicide and to help respond to domestic violence or substance abuse calls. The Mobile Crisis Response Team

(MCRT) will offer help via an already existing 24-hour hotline. Along with offering counseling over the phone, hotline operators will now dispatch licensed mental health clinicians and case managers to crisis locations when needed. The two-person teams can also be requested by first responders such as police officers. It's critical that we get the person in crisis to the appropriate treatment, instead of pushing them into the correctional system. Programs like this can be a great bridge.

6. Can you speak to ways crisis intervention programs like MCRT can impact the mental health system and how the federal government can provide support to this and similar efforts?