This is a preliminary transcript of a Committee hearing. It has not yet been subject to a review process to ensure that the statements within are appropriately attributed to the witness or member of Congress who made them, to determine whether there are any inconsistencies between the statement within and what was actually said at the proceeding, or to make any other corrections to ensure the accuracy of the record.

1 {York Stenographic Services, Inc.}
2 RPTS J. BROWN
3 HIF085.020

4 WHERE HAVE ALL THE PATIENTS GONE?: EXAMINING THE PSYCHIATRIC
5 BED SHORTAGE
6 WEDNESDAY, MARCH 26, 2014
7 House of Representatives,
8 Subcommittee on Oversight and Investigations
9 Committee on Energy and Commerce
10 Washington, D.C.

11 The Subcommittee met, pursuant to call, at 10:02 a.m.,
12 in Room 2123 of the Rayburn House Office Building, Hon. Tim
13 Murphy [Chairman of the Subcommittee] presiding.
14 Present: Representatives Murphy, Burgess, Blackburn,
15 Harper, Griffith, Johnson, Ellmers, DeGette, Braley,
16 Schakowsky, Butterfield, Castor, Tonko, Green, and Waxman (ex
17 officio).
18 Staff present: Leighton Brown, Deputy Press Secretary;

19 Karen Christian, Chief Counsel, Oversight; Noelle Clemente,
20 Press Secretary; Brad Grantz, Policy Coordinator, Oversight
21 and Investigations; Brittany Havens, Legislative Clerk; Sean
22 Hayes, Counsel, Oversight and Investigations; Alan Slobodin,
23 Deputy Chief Counsel, Oversight; Sam Spector, Counsel,
24 Oversight; Tom Wilbur, Digital Media Advisor; Jessica
25 Wilkerson, Legislative Clerk; Brian Cohen, Democratic Staff
26 Director, Oversight and Investigations, and Senior Policy
27 Advisor; Hannah Green, Democratic Staff Assistant; Elizabeth
28 Letter, Democratic Press Secretary; Karen Lightfoot,
29 Democratic Communications Director and Senior Policy Advisor;
30 Anne Morris Reid, Democratic Senior Professional Staff
31 Member; and Stephen Salsbury, Democratic Investigator.

|

32 Mr. {Murphy.} Good morning. I now convene this
33 morning's hearing titled ``Where Have All the Patients Gone?:
34 Examining the Psychiatric Bed Shortage.''
35 Right after the December 14, 2012, elementary school
36 shootings in Newtown, Connecticut, the Subcommittee on
37 Oversight and Investigations began a review of federal
38 programs and resources devoted to mental health and serious
39 mental illness. Recent events have shown the continuing
40 importance of this inquiry, including the September 2013 Navy
41 Yard shooting just a couple of miles from where we sit this
42 morning, in Washington, D.C. Other tragic cases, like Seung-
43 Hui Cho, James Holmes, Jared Loughner, and Adam Lanza, all
44 exhibited a record of untreated severe mental illness prior
45 to their crimes. It is a reflection of the total dysfunction
46 of our current mental health system that despite clear
47 warning signs, these individuals failed to receive inpatient
48 or outpatient treatment for their illnesses that might have
49 averted these tragedies. And they all leave us wondering,
50 what would have happened if--
51 What would have happened if Aaron Alexis was not just
52 given sleeping pills at the VA hospitals, or if there was an
53 available hospital bed or outpatient treatment available for
54 others who later became violent, involved in a crime, unable

55 to pay their bills, or tossed out on the street?

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

69 Nationwide, we face an alarming shortage in inpatient
70 psychiatric beds that, if not addressed, will result in more
71 tragic outcomes. This is part of the long-term legacy of
72 deinstitutionalization, the emptying out of State psychiatric
73 hospitals resulting from the financial burden for community-
74 based care being shifted from the State to the Federal
75 Government. With the deinstitutionalization, the number of
76 available inpatient psychiatric beds has fallen considerably.
77 The number of beds has decreased in the 1950s from 559,000 to
78 just 43,000 today. Back in the 1950s, half of every hospital

79 bed was a psychiatric bed. We needed to close those old
80 hospitals that had become asylums, lockups and, quite
81 frankly, they were dumping grounds.
82 But where did all the patients go? They were supposed
83 to be in community treatment. They were supposed to on the
84 road to recovery. But for many, that simply did not happen.
85 The result is that individuals with serious mental
86 illness who are unable to obtain treatment through ordinary
87 means are in too many cases homeless or entangled in the
88 criminal justice system, including being locked up in jails
89 or prisons.
90 Right now, the country's three largest jail systems in
91 Cook County, Illinois, Los Angeles County; and New York City
92 have more than 11,000 prisoners receiving treatment on any
93 given day and are, in fact, the largest mental health
94 treatment facilities in the country. These jails are many
95 times larger than the largest State psychiatric hospitals.
96 Not surprisingly, neither living on the streets nor
97 being confined to a high-security cellblock are known to
98 improve the chances that an individual's serious mental
99 illness will stabilize, let alone prepare them, where
100 possible, for eventual reentry into the community, to find
101 housing, to find jobs, and to find confidence in their
102 future.

103 It is an unplanned, albeit entirely unacceptable
104 consequence of deinstitutionalization that the State
105 psychiatric asylums, dismantled out of concern for the humane
106 treatment and care of individuals with serious mental
107 illness, have now effectively been replaced by confinement in
108 prisons and homeless shelters and tied to hospital beds.
109 What can we do earlier in people's lives to get them
110 evidence-based treatment, community support, and on the road
111 to recovery, not the road to recidivism? Where is the
112 humanity in saying there are no beds to treat a person
113 suffering from schizophrenia, delusions, and aggression and
114 so that what they are offered is sedation and being
115 restrained in ER hospital bed for days?
116 This morning, to provide some perspective on the far-
117 reaching implications of the current psychiatric bed shortage
118 and to hear some creative approaches to address it, we will
119 be receiving testimony from individuals with a wealth of
120 experience across the full range of public services consumed
121 by the seriously mentally ill across our Nation. These
122 include Lisa Ashley, the mother of a son with serious mental
123 illness who has been boarded multiple times at the emergency
124 department; Dr. Jeffrey Geller, a psychiatrist and co-author
125 of a report on the trends and consequences of closing public
126 psychiatric hospitals; Dr. Jon Mark Hirshon, an ER physician

127 and Task Force Chair on a recent study of emergency care
128 compiled by the American College of Emergency Physicians;
129 Chief Mike Biasotti, immediate past President of the New York
130 State Association of Chiefs of Police and parent of a
131 daughter with serious mental illness; Sheriff Tom Dart, of
132 the Cook County, Illinois, Sheriff's Office, who oversees one
133 of the largest single site county pre-detention facilities in
134 the United States; the Hon. Steve Leifman, Associate
135 Administrative Judge, Miami-Dade County Court, 11th Judicial
136 Circuit of Florida; Gunther Stern, Executive Director of
137 Georgetown Ministry Center, a shelter and clubhouse caring
138 for Washington D.C.'s homeless; Hakeem Rahim, a Mental Health
139 Educator and Advocate; LaMarr Edgerson, a Clinical Mental
140 Health Counselor and Director at Large of the American Mental
141 Health Counselors Association; and Dr. Arthur Evans, Jr.,
142 Commissioner of Philadelphia's Department of Behavioral
143 Health and Intellectual disAbility Services. I thank you all
144 for being with us this morning and giving us so much of your
145 time.

146 [The prepared statement of Mr. Murphy follows:]

147 *************** COMMITTEE INSERT ***************

|

148 Mr. {Murphy.} I would now like to give the ranking
149 member an opportunity to deliver brief remarks on her own.
150 Ms. DeGette.
151 Ms. {DeGette.} Thank you very much, Mr. Chairman. I
152 want to thank you for having this hearing and also for your
153 continued leadership on the important topic of mental health.
154 I want to thank all of the witnesses for appearing before us
155 today. I think this sets a record as the biggest panel we
156 have ever had in this subcommittee, and I am looking forward
157 to hearing each one of your perspectives. It is rare we ever
158 get so much knowledge and such a breadth gathered in one
159 place.
160 Mr. Rahim, I am especially glad that you are here with
161 us this morning. This is our fourth hearing in this
162 subcommittee on mental health during this Congress, but this
163 is the first time we have ever heard directly from somebody
164 who can share his own personal history with mental illness
165 and sit before us as a testament to the possibility of
166 recovery. I know it takes a lot of courage to tell these
167 personal stories in public, and I want to commend you for
168 being here.
169 I also want to commend Ms. Ashley and Mr. Biasotti for
170 being here today as parents because I have been approached by

171 so many parents in my district who know that I am working on
172 these issues, talking to me about the heartbreak of having
173 young adults or teenagers who are dealing with these issues
174 and what it is like as a family member. All of you can add
175 really good perspective to this, and I want to thank you.
176 The question for this hearing, where have all the
177 patients gone, is a very important one. Individuals with
178 serious mental illnesses like bipolar disorder or
179 schizophrenia are showing up in emergency rooms, encountering
180 the criminal justice system and becoming homeless far too
181 often. One reason why this problem is getting worse is
182 because of budget cuts for mental health and addiction
183 services at the State and local level. The American Mental
184 Health Counselors Association reported that between 2009 and
185 2012, States have cut nearly $5 billion in mental health
186 services.
187 Mr. Chairman, I am concerned about the impact of these
188 cuts, and I hope that we can address them today, and also as
189 we continue our joint efforts to work towards comprehensive
190 mental health legislation, how we can address these cuts
191 because, to be honest, if there are no beds for folks to go
192 to, then anything we can do is going to be useless, and so we
193 are going to have to work with State and local governments to
194 figure out how to fund the appropriate amount of beds that we

195 need.

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

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

215 I don't want to downplay the concerns about the lack of
216 inpatient beds for patients who need them. Despite our best
217 efforts, there still will be instances where more intensive
218 interventions are needed. But I hope that we can agree that

219 these should be exceedingly rare occurrences and that having
220 more inpatient beds is only a partial solution. The benefits
221 provided by the Mental Health Parity and Addiction Equity Act
222 and the Affordable Care Act will help prevent these ER crises
223 if implemented correctly. They will provide millions of
224 Americans with access to quality, affordable health insurance
225 that includes coverage for mental health services. We need
226 to build from these laws to support the continuum of mental
227 health services at all levels of government, and I must say,
228 I was very proud that we were able to include mental health
229 parity in the Affordable Care Act. This will be very
230 important for patients.
231 We also need to remember that recovery, even for
232 individuals living with serious mental illness, is possible,
233 or certainly at least management. Mr. Rahim is proof that
234 individuals with access to the right range of services not
235 only can we greatly reduce the number of individuals in
236 crisis winding up in prisons or emergency rooms but we can
237 produce hardworking, contributing members of society as well.
238 As well as your bill that you have introduced, Mr. Chairman,
239 there is a lot of other legislation out there, and I know we
240 intend to continue working together to try to have some kind
241 of comprehensive legislation that will begin to address all
242 of these issues.

243 Thank you so much, Mr. Chairman.

244 [The prepared statement of Ms. DeGette follows:]

245 *************** COMMITTEE INSERT ***************

|

246 Mr. {Murphy.} I thank the gentlelady for her comments,
247 and yes, we will continue to work together.
248 I now recognize the gentlelady from North Carolina, Mrs.
249 Ellmers, if you want to make an opening statement.
250 Mrs. {Ellmers.} Thank you, Mr. Chairman. I just want
251 to make a brief statement, especially due to the size of our
252 panel, and I am very anxious to hear from all of you on these
253 issues.
254 You know, I served as a nurse for 21 years before coming
255 to Congress, and there is nothing that is more heartbreaking
256 than when you see a situation of mental illness and a family
257 who is struggling to deal with that. I just want to say
258 thank you to all of you. I want to take that opportunity
259 because you coming forward will help us to finally deal with
260 the situation, and it is a multifaceted situation and we all
261 have to come together. This is not a political one, this is
262 not one that we can't reach across the aisle and work
263 together on.
264 So thank you to all of you, and God bless all of you.
265 [The prepared statement of Mrs. Ellmers follows:]

266 *************** COMMITTEE INSERT ***************

|

267 Mr. {Murphy.} The gentlelady yields back. Anybody on
268 this side want any more of the remaining time? If not, we
269 will now recognize the ranking member of the full committee,
270 Mr. Waxman, for an opening statement, 5 minutes.
271 Mr. {Waxman.} Thank you very much, Mr. Chairman.
272 Today's hearing addresses an important issue affecting
273 treatment and outcomes for patients with mental illnesses.
274 We will hear today that budget cuts and other factors have
275 resulted in a lack of inpatient beds for intensive
276 psychiatric treatment, meaning that patients with serious
277 mental illness who show up to the emergency room at a crisis
278 point are forced to wait far too long, for days at a time,
279 for an inpatient psychiatric bed.
280 This is a growing problem, but it is not a new one. A
281 decade ago, as ranking member of the Oversight Committee, I
282 released a report finding that all too often, jails and
283 juvenile detention facilities have had to provide care for
284 individuals with mental illnesses. This report found that
285 due to lack of available treatment, youth with serious mental
286 disorders were placed in detention without any criminal
287 charges pending against them. In other cases, youth who had
288 been charged with crimes but who had served their time or
289 were otherwise able to be released remained incarcerated for

290 extended periods of time because no inpatient bed,
291 residential placement or outpatient appointment was
292 available. That investigation found that two-thirds of
293 juvenile detention facilities were holding youth waiting for
294 mental health treatment, and that in one 6-month period,
295 nearly 15,000 incarcerated youth were waiting for mental
296 health services.
297 Mr. Chairman, I share your desire to end these
298 practices. That is why I supported the Affordable Care Act,
299 which provides health insurance coverage, including coverage
300 for mental illness, to millions of Americans, and that is why
301 I have opposed Republicans efforts to repeal this law and
302 take this coverage away. It is also why I hope that this
303 hearing does not ignore the elephant in the room: the impact
304 on millions of Americans with mental illnesses of the failure
305 by 24 States to expand their Medicaid programs under the
306 Affordable Care Act.
307 Last month the American Mental Health Counselors
308 Association released a new study titled ``Dashed Hopes,
309 Broken Promises, More Despair,'' and I would like to ask that
310 this report be made part of the hearing record.
311 Mr. {Murphy.} Without objection, yes, it will be
312 included.
313 [The information follows:]

314 *************** COMMITTEE INSERT ***************

|

315 Mr. {Waxman.} Dr. Edgerson is here today to testify on
316 behalf of the organization, and I appreciate him joining us.
317 The report found that the failure by States to expand
318 their Medicaid programs is causing nearly four million people
319 who are in serious psychological distress or have a serious
320 mental illness or substance disorder to go without health
321 insurance. That is four million Americans in need who are
322 left without coverage, largely because of Republican
323 governors' ideological obsession with rejecting everything
324 associated with the Affordable Care Act.
325 Mr. Chairman, this includes over 200,000 people with
326 mental illnesses in your home State of Pennsylvania.
327 The report described the impact of this lack of
328 coverage, finding that ``The lack of health insurance
329 coverage keeps people with mental illness from obtaining
330 needed services and treatments and follow-up care with the
331 goal of achieving long-term recovery and quality of life.''
332 This is a tragedy and a shame. If these four million
333 Americans obtained coverage, they would receive better
334 ongoing treatment and care, and they would be less likely to
335 end up in a hospital emergency room, or worse, a prison, with
336 a mental health crisis.
337 Mr. Chairman, I know you want to help individuals with

338 mental illnesses. We have both introduced mental health
339 legislation, and I hope that as we move forward, we can find
340 common ground with these bills.
341 But the biggest and easiest step we can take to improve
342 care for those with serious mental illnesses is to make sure
343 they have health insurance. The Medicaid expansion is a good
344 deal for the States, and it is desperately needed by millions
345 of Americans. This committee should be working together to
346 make sure that regardless of where they live, Americans in
347 all 50 states can obtain this coverage.
348 I yield back the balance of my time.
349 [The prepared statement of Mr. Waxman follows:]

350 *************** COMMITTEE INSERT ***************

|

351 Mr. {Murphy.} The gentleman yields back. Thank you.

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

356 [The information follows:]

357 *************** COMMITTEE INSERT ***************

|

358 Mr. {Murphy.} I have already introduced all of our
359 witnesses today, so I am now going to swear you in. So you
360 are aware, the committee is holding an investigative hearing,
361 and we have the practice of taking testimony under oath. Do
362 any of you object to taking an oath? All right. The Chair
363 then advises you that under the rules of the House and the
364 rules of the committee, you are entitled to be advised by
365 counsel. Do any of you desire to be advised by counsel
366 during your testimony today? It shouldn't be an issue.
367 Thank you. In that case, if you would please rise and raise
368 your right hand, and I will swear you in.
369 [Witnesses sworn.]
370 Mr. {Murphy.} You may now sit down, and you are under
371 oath and subject to the penalties set forth in Title XVIII,
372 section 1001 of the United States Code. We will now
373 recognize each of you to give a 5-minute opening statement.
374 I recognize first Ms. Ashley. Make sure your microphone
375 is on and it is pulled close to you. Thank you.

|

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

399 DEPARTMENT OF BEHAVIORAL HEALTH AND INTELLECTUAL DISABILITY
400 SERVICES, UNIVERSITY OF PENNSYLVANIA, PHILADELPHIA,
401 PENNSYLVANIA

|

402 ^TESTIMONY OF LISA ASHLEY

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

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

413 My son was about 20 or 21 years old when I knew
414 something was wrong but it wasn't until he went homeless when
415 he was in L.A. and went missing for 3 weeks that I knew for
416 sure. Of course he saw nothing wrong. When I was finally
417 able to locate him, I brought him back to Sacramento. He
418 was delusional, thinking the FBI was watching him, there
419 were satellites in the sky monitoring his thoughts, having
420 auditory hallucinations, could not have a conversation,

421 laughing to himself, and not caring for his hygiene. Prior
422 to this, my son was extremely bright, received 740 out of
423 800 on his math SATs, was accepted to seven universities for
424 mechanical engineering. His bizarre behavior went on for
425 months but he refused to see a psychiatrist. He was bonded
426 to his primary medical provider, who saw him for several
427 times trying to get him on a hold. I felt helpless and
428 extremely frustrated. Even calling the police did not help
429 because they did not feel that he was a harm to himself or
430 others.

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

438 The first time was in May 2012. He had been a sick over
439 a year before I was able to get him some help. His first
440 time in the emergency room was approximately 12 hours. I
441 couldn't believe they had to hold him there that long, not
442 knowing there was a shortage of psych beds in the county. He
443 was then transferred to a psych facility locally and remained
444 2 weeks, just as long as my insurance would allow him.

445 Although it was very difficult to have my son hospitalized, I
446 know he was in good hands and relieved some of my anxiety,
447 but still, it was nothing like I had ever been through and
448 having to trust a system that was so foreign to you and
449 difficult, I worried every minute.

450 The second time was not quite as smooth. In January of
451 2013, my son asked voluntarily to be taken to the hospital
452 because his head felt like it was on fire. He was anxious
453 and very distressed. I dropped everything, knowing that he
454 was asking to go, he must have felt pretty bad. I brought
455 him to the same emergency room that morning, reached the
456 triage nurse. I identified myself as an employee and a nurse
457 practitioner. I explained my son was a paranoid
458 schizophrenic and he was in psychosis. I tried to remain
459 calm as the triage nurses took his blood pressure and
460 temperature and then assigned him to a gurney in the hallway
461 with at least eight other patients, which included children,
462 all waiting to be seen by a doctor. It was not long before
463 my son started to get agitated and wanting to leave. The
464 R.N. called the social worker to help intervene. She could
465 not quiet him down. As he tried to approach the exit, the
466 emergency room policeman tried to stop him by holding him
467 back. His behavior escalated. My son was screaming at him
468 not to touch him. When schizophrenics are in psychosis, they

469 do not want to be touched. In front of all the children and
470 adults waiting in the hallway, the police officer wrestled
471 him to the ground and handcuffed him.

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

482 They then placed him on a gurney and put him in four-
483 point restraints and they medicated him. He was there on a
484 Friday morning the whole day, all day Saturday, all day
485 Sunday and all day Monday afternoon because they could not
486 find a psych bed anywhere. He stayed in a room tied to his
487 bed for four days, heavily medicated. Seeing him helpless
488 tied to a bed for days was like a nightmare. This was my
489 son, and I was helpless except to keep him company and try to
490 reassure him things would be all right. I was angry they
491 couldn't find him a place. Does it really take that long to
492 find a psych bed?

493 Finally, on Monday, I was told there was an opening at a
494 hospital in San Francisco, which is 100 miles east of
495 Sacramento. They finally took him there later that day. I
496 was unable to be involved in his care because he was so far
497 away except for weekends. It was very frustrating. I didn't
498 understand why he needed to go so far away from his family
499 member, who cared for him and loved him.
500 By the way, if I hadn't had private insurance, he never
501 would have gone to that hospital because they don't accept
502 public monies, so because I had private insurance, they took
503 him. Otherwise, who knows? He might still be there.
504 The third time was in November. Again, his head was
505 burning and voices were screaming at him. I took him back to
506 the hospital. They put him on a gurney in the hallway again.
507 I was able to be proactive and talk with other providers
508 prior to this, and set up a plan so that the second
509 intervention would never, ever happen to him again. I was
510 able to make some phone calls, and after two days get him
511 into a local psych facility, where he stayed another 3 days.
512 My son is fairly stable since that time in November. He
513 has not required any additional hospitalization but he
514 attends regular psychiatric visits and takes his medications
515 regularly, and I pray every day that he continues to stay out
516 of the emergency room because there are no other alternatives

517 for him.

518 Thank you.

519 [The prepared statement of Ms. Ashley follows:]

520 *************** INSERT A ***************

|

521 Mr. {Murphy.} Thank you, Ms. Ashley. I appreciate your
522 moving testimony.
523 I forgot to mention at the time to keep your comments to
524 5 minutes, so if you hear my gavel tapping, that is why.
525 Doctor, you are next.

|

526 ^TESTIMONY OF JEFFREY L. GELLER

527 } Dr. {Geller.} Mr. Chairman, Representatives, ladies and
528 gentlemen, good morning. I am Dr. Jeffrey Geller, a board-
529 certified psychiatrist, currently Professor of Psychiatry at
530 the University of Massachusetts Medical School, Medical
531 Director of the Worcester Recovery Center and Hospital, and
532 Staff Psychiatrist at the Carson Community Mental Health
533 Center.
534 I have consulted to public mental health systems and
535 State hospitals in one-half of the States in the United
536 States, the District of Columbia and Puerto Rico. I am the
537 author of 250 publications in the professional literature,
538 and the book, ``Women of the Asylum.'' I serve on many
539 professional boards but I come here today representing only
540 my own experience taking care of patients with serious mental
541 illness for 40 years.
542 Just yesterday, there were 22 psychiatric patients in a
543 general hospital emergency room in a city of 150,000 not far
544 from here waiting for disposition. Why? What is to be done?
545 On May 3, 1854, President Franklin Pierce vetoed a bill
546 that would have made the Federal Government responsible for
547 America's population with serious mental illness. His veto

548 message includes the following beliefs of his: State
549 hospitals or public psychiatric hospitals are meritorious
550 institutions doing good. They fulfill a historic role
551 belonging to the States, meeting the needs of a population
552 outside the purview of the Federal Government and susceptible
553 to becoming the responsibility of the Federal Government if
554 the Federal Government provided any opportunity to the States
555 to shift the burden.
556 The Federal Government left the care of the serious
557 mentally ill to the States until Congress passed and
558 President Kennedy signed the Mental Retardation Facilities
559 and Community Mental Health Centers Construction Act of 1963.
560 From then until now, federal actions such as Medicaid,
561 Medicare, the IMD exclusion and many others have resulted in
562 the unintended consequences of massive proportions, not the
563 least of which is deinstitutionalization. We created the
564 perfect formula for the current debacle: an expanding array
565 of fiscal incentives for States to move people out of state
566 hospitals, inadequate resources to meet the needs of State
567 residents with serious mental illness in the community, no
568 beds in State hospitals to meet the needs of former State
569 hospital patients, who did not find the community the panacea
570 promised by the Supreme Court and were dangerous outside of
571 hospitals, no beds to meet the needs of new cases of serious

572 mental illness requiring a hospital level of care, and a
573 public more willing to build jails and prisons than hospitals
574 because they found no solace in a state system they saw as
575 pushing ill-prepared folks with mental illness into their
576 neighborhoods.

577 How did this lead to individuals waiting in hospital
578 emergency departments, or EDs, for weeks, sometimes a month?
579 Pick any State. There are no available beds in the State's
580 public psychiatric hospitals because there are too few beds.
581 A patient on the psychiatric unit in a general hospital has
582 been approved for transfer to the State hospital but cannot
583 be transferred because there is no available bed. Thus, the
584 general hospital psychiatric unit is populated by some
585 patients who are stuck there awaiting state hospital
586 transfer. An individual is brought to the general hospital's
587 emergency department by police, family, ambulance, or comes
588 on her own. The individual was assessed and determined to
589 need hospitalization. The individual cannot be admitted to
590 the psychiatric unit in the same hospital as the emergency
591 department because there are no beds there.

592 What happens next is, a hospital emergency department
593 staff or a member of a contracted crisis team starts a bed
594 search. A bed search means calling every hospital in the
595 State seeking a bad. Frequently, the bed search is

596 fruitless. There are no beds available anywhere because all
597 the hospitals are in the same situation as the psychiatric
598 unit in the hospital the worker is calling from. So the
599 individual remains in the emergency department waiting for an
600 available bed. The days waiting benefit no one. The ED
601 becomes overcrowded. The patient is a patient in name only.
602 He is not getting treatment except that he is receiving food,
603 a bed or gurney, and maybe some medication. He might as well
604 be waiting on a bench in a train station. Or the individual
605 is simply released from the emergency department because
606 there is no place else for her to go. The threshold for
607 holding somebody in the emergency department awaiting
608 admission keeps creeping up. Many released folks are picked
609 up by the police, processed through the courts, sent to the
610 State hospital for a forensic evaluation, further decreasing
611 available beds to the person awaiting a bed in the emergency
612 department.

613 Congress can enact measures to ameliorate the problems
614 of boarders in emergency departments. These include:
615 provide States with opportunities to obtain IMD exclusion
616 waivers with maintenance of effort; make SSI and SSDI
617 payments to eligible individuals independent of where they
618 reside and require their contribution for room and board to
619 be the same in all locations including jails and prisons;

620 individuals keep their Medicaid and Medicare in all settings.
621 Improve the federal grant process for research into
622 prevention and early intervention; provide grants to States
623 to create or expand crisis intervention teams so that such a
624 program is available in every city and town; set fair and
625 reasonable Medicaid payment rates for psychiatric services at
626 community mental health centers and Federally Qualified
627 Health Centers; incentivize States to actually use the
628 assisted outpatient treatment statutes they have; define
629 Medicaid and Medicare payments to clubhouses in ways that do
630 not destroy the mission of clubhouses; incentivize States to
631 establish mental health courts.
632 Mr. Chairman, Representatives, it is time the Federal
633 Government took explicit action through bipartisan, bicameral
634 efforts to remedy the calamitous state of the public care and
635 treatment of persons with serious mental illness in the
636 United States today.
637 Thank you.
638 [The prepared statement of Dr. Geller follows:]

639 *************** INSERT B ***************

|

640 Mr. {Murphy.} Thank you, Doctor.

641 Dr. Hirshon, you are recognized for 5 minutes.

|

642 ^TESTIMONY OF JON M. HIRSHON

643 } Dr. {Hirshon.} In emergency departments throughout the
644 country, we emergency physicians expect the unexpected. This
645 is what we are trained to do. Even so, there is one thing
646 that we all know is happening: increasing demand by patients
647 in need of acute psychiatric care.
648 Mr. Chairman and members of the subcommittee, thank you
649 for this opportunity to testify today on behalf of the
650 American College of Emergency Physicians. ACEP is the
651 largest specialty organization in emergency medicine with
652 more than 32,000 members in all 50 States and the District of
653 Columbia.
654 My purpose today is to help you understand that we are
655 in the midst of a national crisis, facing a dramatic increase
656 in vulnerable mental health patients seeking emergent and
657 urgent care. America's mental health services are
658 experiencing increasing demand while concurrently receiving
659 decreased funding, which drives psychiatric patients to the
660 ED, or emergency department.
661 In 2000, psychiatric patients to the ED accounted for
662 only 5.4 percent of all ED visits, but by 2007, that number
663 had risen to 12.5 percent, well over a doubling of the number

664 of psychiatric patients. Until more services and funding are
665 made available to address this crisis, EDs will be the safety
666 net for these patients. This is due in large part to the
667 federal Emergency Medicine Treatment and Labor Act, EMTALA,
668 which mandates medical screening evaluation and stabilization
669 for anyone seeking care in an ED. Additionally, unlike many
670 other health care settings, EDs are open 24 hours a day, 7
671 days a week every day of the year.

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

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

686 In a recent ACEP survey, 99 percent of emergency
687 physicians reported admitting psychiatric patients daily

688 while 80 percent said that they were boarding psychiatric
689 patients in their EDs. Acutely ill psychiatric patients
690 require more physician, more nurse and more hospital
691 resources. ED staff spends more than three times as long
692 looking for a psychiatric bed as they would for a non-
693 psychiatric patient.

694 Other factors contribute to the extended ED boarding
695 times for psychiatric patients including defensive medicine
696 or threat of legal action, required preauthorization for
697 inpatient services, medical clearance prior to psychiatric
698 evaluation, substance abuse-related issues, and inadequate
699 outpatient services. As communities have seen, many of these
700 issues are systems issues and beyond the control of the
701 clinician. It is imperative that access to high-quality
702 inpatient and community mental health care be a priority.

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

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

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

731 I thank you for your attention to this alarming problem.

732 [The prepared statement of Dr. Hirshon follows:]

733 *************** INSERT C ***************

|

734 Mr. {Murphy.} Thank you, Doctor.

735 Chief Biasotti, you can pull that microphone right up

736 next to you, please. Thank you.

|

737 ^TESTIMONY OF MICHAEL C. BIASOTTI

738 }   Chief {Biasotti.} Good morning, Chairman Murphy and Ms.
739 DeGette. I am the immediate past President of the New York
740 State Association of Chiefs of Police and Chief of Police in
741 New Windsor, New York. I am in my 38th year of service.
742   My wife, Barbara, who is a psychologist, is here today
743 with me. We have a daughter with schizophrenia who has been
744 involuntarily hospitalized in excess of 20 times. Barbara
745 and I met when she, like many moms, turned to the police for
746 help when her, now our daughter became psychotic, disruptive
747 and threatening. She was self-medicating, unemployed and
748 deteriorating, despite my wife's heroic efforts to help her.
749 Then she went into assisted outpatient treatment. It saved
750 her life.
751   In 2011, while at the United States Naval Postgraduate
752 School's s Center for Homeland Defense and Security, I
753 published a survey of over 2,400 senior law enforcement
754 officers titled ``Management of the Severely Mentally Ill and
755 its Effect on Homeland Security.'' It found that the
756 mentally ill consume a disproportionate percentage of law
757 enforcement resources. Many commit low-level crimes. A
758 hundred and sixty thousand attempt suicide, 3 million become

759 crime victims, and 164,000 are homeless each year.
760 The survey essentially found that we have two mental
761 health systems today, serving two mutually exclusive
762 populations. Community programs serve those who seek and
763 accept treatment. Those who refuse, or are too sick to seek
764 voluntary treatment, become law enforcement responsibilities.
765 Officers in the survey were frustrated that mental health
766 officials seemed unwilling to recognize or take
767 responsibility for this second more symptomatic group.
768 Ignoring them puts patients, the public and police at risk
769 and costs more than keeping care within the mental health
770 system.
771 As an example, there are fewer than 100,000 mentally ill
772 in psychiatric hospitals but over 300,000 in jails and
773 prisons. The officers I surveyed pointed out the drain on
774 resources it takes to investigate, arrest, fill out paperwork
775 and participate in the trials of all of them. Add to that
776 the sheriffs, district attorneys, judges, prisons, jails and
777 correction officers it takes to manage each of them and you
778 see the scope of the problem.
779 Many more related incidents, like suicides, fights and
780 nuisance calls take police time, but don't result in arrest
781 or incarceration. Overly restrictive commitment standards
782 and the shortage of hospital beds are major sources of

783 frustration for officers. Hospitals are so overcrowded they
784 often can't admit new patients and discharge many before they
785 are stable. They become what we call round trippers or
786 frequent flyers. One officer referred to it as a human catch
787 and release program. Anyone who asks for help is generally
788 not sick enough to be admitted, so involuntary admission,
789 that is, being a danger to self or others, becomes the main
790 pathway to treatment. Officers are called to defuse
791 situations and then have to drive in some cases hours to
792 transport the individual to hospitals and then wait hours in
793 the emergency rooms, only to find the hospital refuses
794 admission because there are no beds or that the commitment
795 standard is so restrictive. The only remaining solution for
796 our officers is to arrest these people with serious mental
797 illness for whatever minor violation exists, something that
798 they are loathe to do to sick people who need medical help,
799 not incarceration.
800 Finally, while everyone knows that everyday mental
801 illness is not associated with violence, untreated serious
802 mental illness clearly is. The officers in the survey deal
803 with that reality every day. You in Congress dealt with it
804 when Ronald Reagan and Gabrielle Giffords were shot; two
805 guards in the Capitol building were killed, and the Navy Yard
806 shootings happened. Representatives DeGette, Gardner and

807 Griffiths have experienced the worst of the worst in their
808 States.

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

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

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

831 than treatment after tragedy.

832 Thank you so much.

833 [The prepared statement of Chief Biasotti follows:]

834 *************** INSERT D ***************

835 Mr. {Murphy.} Thank you, Chief.

836 Mr. Dart, you are recognized for 5 minutes.

|

837 ^TESTIMONY OF THOMAS J. DART

838 } Sheriff {Dart.} Thank you, Mr. Chairman and the
839 committee, for having me here today.
840 I am the Sheriff of Cook County, and as the Sheriff, I
841 run the Cook County Jail, which is the largest single site
842 jail in the country. My office is in the jail. Our average
843 daily population is between 10,000 to 12,000 inmates and
844 costs about $143 a day to house someone there.
845 Since becoming Sheriff in 2006, I have seen an explosion
846 in the percentage of seriously mentally ill individuals
847 housed in the jail. I have seen firsthand the devastating
848 impact cuts to mental health programs and services has had on
849 the mentally ill in Illinois. This is a crisis we must all
850 care about because it affects all of us. I find it ironic
851 that in the 1950s we thought it was inhumane to house people
852 in state hospitals but now in the 21st century we are okay
853 with them being in jails and prisons.
854 On any given day, an average of 30 to 35 percent of my
855 population suffers from a serious mental illness. The
856 diagnoses fall into two main categories: mood disorders such
857 as major depressive disorder or bipolar disorder, or a
858 psychotic disorder such as schizophrenia. While some

859 mentally ill individuals are charged with violent offenses,
860 the majority are charged with crimes seemingly committed to
861 survive, including retail theft, trespassing, prostitution
862 and drug possession.
863 A cursory review of our statistics tells the story.
864 Last year in one of my living units, 1,265 men were in that
865 dorm on low-level drug-related offenses. The average length
866 of stay was 87 days. At $143 a day, it costs over $12,000
867 just to house these individuals pretrial because they cannot
868 afford to post a minimal bail or have nowhere to live. Many
869 of these inmates ultimately sentenced to probation, more
870 often than not, or sentenced to time while they were sitting
871 with me.
872 The unfortunate and undeniable conclusion is that
873 because of dramatic and sustained cuts in mental health
874 funding, we have criminalized mental illness in this country
875 and county jails and State prison facilities are where the
876 majority of mental health care and treatment is administered.
877 Three recent case studies illustrate this. J.J. was
878 arrested by the Chicago Police Department last May after a
879 failed attempt to steal sheets or towels from a local
880 Walgreens drug store. When we spoke to him shortly after his
881 arrest, he explained that he took the item off the shelf and
882 as walked past the cashier and he asked her to charge them.

883 He was arrested and charged with retail theft. The value of
884 the items he stole were $29.99. He spent 110 days in my jail
885 before being sentenced to probation. During his custody, he
886 was stabilized on medication and received drug and mental
887 health treatment. The taxpayers of Cook County spent close
888 to $16,000 after a failed attempt to steal $29.99 worth of
889 merchandise from Walgreens.

890 J.D. suffers from a psychotic disorder and has visions
891 that terrify him. He was arrested in California on a warrant
892 from my county. While in custody in California, he removed
893 one of his eyeballs in an attempt to stop seeing the visions.
894 He lost sight in that eye. So we were alerted to this issue.
895 He was transferred to our custody 2 weeks ago and recently
896 attempted to remove his other eye. While staff acted
897 quickly, we were able to stop that from occurring. We
898 presently have him where he wears a helmet and face mask and
899 has gloves on his hands.

900 T.A. was arrested over 100 times. Her most recent
901 arrest came after she attempted to steal $20 from a person's
902 purse during a church service. She is a chronic self-
903 mutilator. She attacks her arms with her own fingernails or
904 any objects she can find. To keep her safe while in our
905 custody, we make special mittens for her that go up to her
906 armpits. Incredibly, she was sentenced to a prison term and

907 recently was transferred to State hospital. We are awaiting
908 right now her imminent return to Chicago. She has cost us,
909 conservatively, the taxpayers, over a million dollars for all
910 of her custody.

911 What we have done in our county now is my staff
912 interviews every detainee before they appear in bond court
913 regarding their mental health history. Those who admit to a
914 history are identified for the public defender's office and
915 then we make efforts to try to appeal to the judges for
916 alternative programs. Unlike State prisoners who have fixed
917 release dates, pretrial detainees may be released at any
918 time, which significantly complicates our ability to provide
919 discharge planning. The inmates are offered written
920 information on available community resources and enrollment
921 in County Care and allowed access to a telephone to contact
922 someone to arrange for transportation home or to identified
923 housing. If the inmate requires discharge to a facility in
924 the next day, we will shelter them overnight before we will
925 try to get them to a hospital. If the inmate requires
926 assistance with transportation to his or her home or a
927 shelter, we will drive them there. If the inmate is stable,
928 coordinated releases are typically initiated by our health
929 care provider and the steps are followed. Additionally, we
930 communicate with the party the inmate is being released to.

931 Once it is confirmed the party is outside the jail, someone
932 from our records unit will go out there to make sure that
933 person is there. The past practice always had been, we
934 released them out to the street where they would wander
935 around aimlessly for hours, if not days.

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

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

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

955 mental health crisis in this county and in the country. I
956 see the pain of those suffering from mental illness and the
957 pain of their families who have struggled to care for them
958 and provide them with resources. The question that plagues
959 me, that keeps me up at night, is where do we go from here?
960 As that question is debated, I will continue to do all I
961 can to care for, protect and advocate for increased funding
962 to address mental illness in our country and I will continue
963 to provide the best care I can for the mentally ill. This is
964 truly a crisis that we can no longer ignore.
965 Thank you.
966 [The prepared statement of Sheriff Dart follows:]

967 *************** INSERT E ***************

|

968 Mr. {Murphy.} Thank you, Sheriff.

969 I now recognize Judge Leifman for 5 minutes.

|

970 ^TESTIMONY OF STEVE LEIFMAN

971 } Mr. {Leifman.} Thank you very much, Mr. Chairman,
972 members of the subcommittee. My name is Steve Leifman. I am
973 a Judge for Miami-Dade County and I chair the Florida Supreme
974 Court Task Force on Substance Abuse, Mental Illness and
975 Issues in the Court.
976 You asked where have the patients gone. Sadly, the
977 answer is jail and prisons, and this is an American travesty.
978 As you already stated, in 1955 there were some 550,000 people
979 in State psychiatric hospitals around this country. If
980 nothing had changed and we use today's population, there
981 would have been about 1.5 million people in State psychiatric
982 hospitals today.
983 Last year, 1.5 million people with serious mental
984 illnesses were arrested in this country. On any given day in
985 the United States, we have approximately 500,000 people with
986 serious mental illnesses in jails and prisons and another
987 850,000 in the community on some type of community control or
988 probation. Since 1955, we have closed 90 percent of the
989 hospital beds in this country and we have seen a
990 corresponding increase of 400 percent of the number of people
991 going to jail with mental illnesses, and because jails are

992 not conducive to treatment and courts do not know what to do
993 with this population, people with mental illnesses generally
994 stay four to eight times longer in jail than anyone else with
995 the exact same charge who does not have a mental illness and
996 costs seven times more.

997 I had no idea that when I become a judge I was actually
998 becoming the gatekeeper to the largest psychiatric facility
999 in the State of Florida, and tragically, that is the Miami-
1000 Dade County Jail. I see more people on any given day with
1001 mental illness than most psychiatrists see in a month.

1002 People with mental illnesses in this country are three
1003 times more likely to be arrested than to be hospitalized, and
1004 in my State, it is nine times more likely. The closing of
1005 the hospitals is not the only and primary reason all these
1006 individuals had ended up in hospitals. It is a combination
1007 that created the perfect storm. It includes the IMD
1008 exclusion. It includes what Medicaid pays for its services.
1009 It includes the war on drugs. It includes the reduction of
1010 hospital beds. It includes the antiquated involuntary laws.
1011 They have all conspired to create this perfect, perfect
1012 storm. And if this wasn't bad enough, just listen to the
1013 costs this is having to our communities.

1014 We worked with the Florida Mental Health Institute at
1015 the University of South Florida and Tampa. We wanted to know

1016 who the highest utilizers of criminal justice and mental
1017 health services were in my county so that we could wrap our
1018 arms around this population to see if we could get them
1019 services so they didn't keep reoffending. I thought I would
1020 get a list of thousands of individuals back. They send me a
1021 list of 97 people, and I guarantee every one of you have
1022 these same 97 in your communities. These 97 individuals,
1023 primarily men, primarily diagnosed with schizophrenia, over 5
1024 years were arrested 2,200 times. They spent 27,000 days in
1025 the Dade County Jail, 13,000 days at a psychiatric hospital
1026 or an emergency room, and cost taxpayers $13 million, and we
1027 got absolutely nothing for it. We would have been better off
1028 sending them to Harvard and maybe giving them an opportunity
1029 for an education. It is an outrage.
1030 The other part of the problem is that where we spend our
1031 money is killing us. In Florida, we spend one-third of all
1032 of our adult public mental health dollars--that is almost a
1033 quarter of a billion dollars--to try to restore competency
1034 for 2,700 people. We have between 170,000 and 180,000 people
1035 in any given year in Florida who at the time of their arrest
1036 need acute mental health care treatment but we spend a third
1037 of our money trying to restore competency so we can try these
1038 2,700 people. Well, 70 percent of these individuals have
1039 three things happen to them. Either the charges are dropped

1040 because the witnesses disappear, they get credit time served
1041 because they have been in the system so long and they walk
1042 out of the front door of the courthouse without any access to
1043 treatment, or they get probation and they walk out of the
1044 courthouse with any access to treatment and we just spent a
1045 quarter of a billion dollars, and that money is coming out of
1046 the community mental health system, making it harder for
1047 people to get access. It actually meets the definition of
1048 insanity. We keep doing the same thing again and again and
1049 we expect a different outcome.
1050 It is even worse at the prison level, and on the
1051 competency restoration, in the United States we are spending
1052 almost $3.5 billion and we are getting very little return for
1053 that money.
1054 The fastest growing population in Florida's prisons are
1055 people with mental illnesses. While our prison population
1056 has begun to stabilize over the last 2 years, the mental
1057 health population continues to grow at exceedingly alarming
1058 rates. Over the last 15 years, the percentage of people with
1059 mental illnesses has grown by 178 percent. We went from
1060 about 6,500 people with serious mental illnesses 15 years ago
1061 to 18,000 today. It is growing so fast that it is projected
1062 to double again in the next 10 years. Florida needs to start
1063 building 10 new prisons for the next 10 years just to get to

1064 this population. It will cost my State $3.5 billion to deal
1065 with this population if we don't do something soon to correct
1066 the problem.
1067 We are looking at a huge cost and we are getting very
1068 little for our income. We have a three-legged stool that is
1069 wobbling and about to break, and there are three parts that I
1070 really hope that you are able to address. The first part is
1071 how and what we finance through federal Medicaid dollars for
1072 mental health services. It doesn't work. The second
1073 somebody is no longer a danger to self or others, Medicaid
1074 will cut the off and the hospital will discharge them back to
1075 the community, often to homelessness, often into the criminal
1076 justice system.
1077 The second part that needs to be addressed is the
1078 antiquated involuntary hospitalization laws. Most of these
1079 laws were written before we had TV, microwave ovens,
1080 computers, brain imaging and antipsychotic medication. It is
1081 an absurdity. The first laws come from 1788 out of New York.
1082 It doesn't work. People cannot get into the system to get
1083 treatment, and then when they are ready to be discharged,
1084 there is nothing for them.
1085 The third part is that we need to have a coordinated
1086 system in the criminal justice system to make sure we can
1087 take care of this population, and let me just make two quick

1088 points. We are doing some significant things in Miami-Dade
1089 County that are having huge impacts. We have trained over
1090 4,000 police officers in order to identify people with mental
1091 illnesses in the community. Last year, the city of Miami and
1092 Miami-Dade County did 10,000 mental health calls. These
1093 4,000 officers only made 27 arrests out of these 10,000
1094 calls. Our jail audit plummeted from 7,800 to 5,000,
1095 allowing the county to close a jail and saving $12 million.
1096 We also have post-arrest diversion programs where if someone
1097 comes in, we get them treated and make sure that they are not
1098 just discharged to the community without any assistance.
1099 We are saving lives, we are saving dollars, and we are
1100 starting to make the system work, but we need to fix those
1101 other three pieces. We also need to begin to use advanced
1102 technology, which we are beginning to do. We are part of a
1103 unique private and public partnership in Dade County where we
1104 are working to see if predictive analytics can actually be
1105 used in the behavioral health space so that we can have an
1106 unfragmented system of care, more accountability, and make
1107 sure that people with mental illnesses are treated fairly and
1108 properly.
1109 Thank you very much.
1110 [The prepared statement of Judge Leifman follows:]

1111 *************** INSERT F ***************

|

1112 Mr. {Murphy.} Thank you, Judge. I was afraid to gavel
1113 a judge.
1114 Judge {Leifman.} And I appreciate that, and I won't
1115 hold anyone in contempt today, so appreciate the
1116 reciprocation.
1117 Mr. {Murphy.} I don't think this is your jurisdiction,
1118 so we are good.
1119 Judge {Leifman.} Thank you.
1120 Mr. {Murphy.} But thank you for your testimony.
1121 Mr. Stern, you are recognized for 5 minutes.

|

1122 ^TESTIMONY OF GUNTHER STERN

1123 } Mr. {Stern.} Thank you for hearing me today. I am here
1124 to talk about people are homeless with severe, untreated
1125 mental illness. I have been working with homeless people for
1126 nearly 30 years, for the last 24 at Georgetown Ministry
1127 Center. Our goal back in 1990 was to prosecutor ourselves
1128 out of business by ending homelessness. Instead,
1129 homelessness has become a career for me and so many others.
1130 It has now been 10 years since cities around the country
1131 including Washington, D.C., issued their 10-plan to end
1132 homelessness. Not much has changed.
1133 Why is homelessness so hard to solve? From my
1134 perspective, it is because we lack the tools to intervene
1135 when a person's life has devolved to the point where he or
1136 she has moved out onto the street because of an untreated
1137 mental illness. When I began work with the homeless
1138 population nearly 30 years ago, deinstitutionalization was in
1139 full swing. At the time many people I was working with were
1140 cycling in and out of hospitals. The community mental health
1141 centers were trying to figure out what their role was.
1142 As deinstitutionalization has continued, I have noticed
1143 that it is increasingly harder to access beds for people in

1144 acute psychiatric crisis. In the past 2 years, I have only
1145 seen two people admitted to the hospital. More typically
1146 now, people referred for psychiatric crisis get poor or no
1147 intervention and are returned to the street, almost always
1148 because they refuse treatment.

1149 Georgetown Ministry Center brings free psychiatric and
1150 medical care to the streets but very few people with
1151 untreated mental illness are willing to engage in
1152 conversations with our psychiatrists about their mental
1153 health. It is the nature of the illness.

1154 However, when we talk about a shortage of beds for
1155 treatment, we are not talking about the people I work with
1156 because these people with limited or no insight into their
1157 illness don't think they need treatment and vehemently refuse
1158 treatment when it is offered.

1159 Homeless people are real people with families like yours
1160 and mine, families that care. Greg is someone I met sitting
1161 on a park bench near our center. He was shabbily dressed and
1162 smelled bed. He would drink, I assume to tame the voices
1163 that I knew he heard because of the frequent spontaneous
1164 smiles and grimaces. All this belied the fact that Greg was
1165 once a gifted constitutional lawyer who delighted his
1166 children with his dry wit. They were in their late teens
1167 when he began to show the signs of what would become a

1168 profoundly disabling bipolar disorder. Not long after, he
1169 disappeared. He would call occasionally on birthdays or out
1170 of the blue for no reason. The kids tried so hard to keep up
1171 with him. They wanted desperately to make him whole again
1172 but it was futile. Greg drifted from city to city around the
1173 country, ending up in our center, ultimately in our small
1174 shelter one winter 8 years ago. Greg was a delight some of
1175 the time. His thick southern drawl and witty conversation
1176 would enchant volunteers, but other times he was withdrawn
1177 and surly. In January of 2006, Greg became sick. We
1178 encouraged him to go to the hospital and he said that he
1179 would. Instead, he disappeared. A week later I received a
1180 call from the medical examiner's office. They needed a body
1181 identified. It was Greg. The bodies never look the way you
1182 remember a person. Only Greg's face and hair showed from the
1183 white shroud covering his body. It took a few moments to
1184 work out that these were the features of the person that I
1185 once knew.

1186 A few years later, I met Greg's two adult children.
1187 They had learned he had died in Washington 3 years after the
1188 fact. Each of them traveled, one from New York, the other
1189 from Phoenix, to meet here and see the place where their dad
1190 spent his final days. They needed to know what his last days
1191 were like. I shared coffee with them, and they told stories

1192 about him and they asked questions about his final days.
1193 They laughed and they cried. You could tell that they loved
1194 and missed their father.
1195 There are so many stories I could tell if I had time
1196 about mothers, brothers, sons, daughters who have wept for
1197 their relatives lost to mental illness. If the families had
1198 the tools to intervene, they would intervene.
1199 Most of all, what I want to impart here is that people
1200 who live on the street are real people with families and
1201 hopes and dreams abandoned because of an illness that has
1202 robbed them of their competency. The other important
1203 takeaway is that almost all the people I see on the street
1204 are there because they have refused treatment, not for
1205 rational reasons but because illness has insidiously robbed
1206 them of their insight to understand that they have an illness
1207 and that treatment can help them.
1208 So finally, what I have concluded after nearly 30 years
1209 of working with people who are homeless is that all I can do
1210 is provide some comfort and harm reduction. Until we are
1211 given tools for more assertive interventions, we will not
1212 resolve homelessness.
1213 Thank you.
1214 [The prepared statement of Mr. Stern follows:]

1215 *************** INSERT G ***************

|

1216 Mr. {Murphy.} Thank you, Mr. Stern.

1217 Mr. Rahim, you are recognized for 5 minutes.

|

1218 ^TESTIMONY OF HAKEEM RAHIM

1219 } Mr. {Rahim.} Chairman Murphy, Ranking Member DeGette
1220 and members of the subcommittee, my journal with mental
1221 illness began in 1998 during my freshman year at Harvard
1222 University. That fall I experienced a terrifying panic
1223 attack. In that episode I had heart palpitations, sweaty
1224 palms and dizziness yet I did not know it was an anxiety-
1225 induced state. What I did know, however, was the deep terror
1226 I felt.

1227 My journey continued when I had my first manic episode.
1228 During the spring of 1999, I roamed the streets of Hempstead,
1229 New York, possessed with a prophetic delusion that I had to
1230 share with any and every one I met. Concerned, my parents
1231 sent me to my father's homeland of Grenada to relax and be
1232 with family. However, while there, I plunged into a deep
1233 depression. I returned to Harvard that fall and struggled
1234 through the year battling anxiety and depression.

1235 In the spring of 2000, I was consumed by my second manic
1236 episode. My next 2 weeks were filled with sleepless nights
1237 and endless writing sessions. I showered less frequently and
1238 ate sporadically. During this manic episode, I experienced
1239 psychosis. I had visions of Jesus, heard cars talking and

1240 spoke foreign languages. Upon hearing my condition, my
1241 parents rushed to pick me up from Harvard's campus. That
1242 same evening, my parents decided to take me a psychiatric
1243 hospital in Queens. When we arrived to the emergency room, I
1244 was taken to the triage area. Over the next few hours, I was
1245 held in a curtained room in the ER. I tossed and turned and
1246 remained restless, as now I had not slept in 24 hours. My
1247 parents sat in the curtained room with me until I was
1248 admitted to the hospital later that night.

1249 Accompanied by two hospital aides, I was transported to
1250 the psychiatric ward in a hospital van. I walked through the
1251 dimly let ward door and was met by approximately six staff
1252 members. They gave me a hospital gown, requested I change
1253 into it, and encouraged me to relax when they noted my
1254 agitated state. When I continued to toss, the staff stated
1255 they were going to put straps around my arms and legs. After
1256 placing the straps, they then said they were going to give me
1257 a sedative to help me sleep. I felt a prick on my upper arm.

1258 The next morning I awoke, drowsy and unable to speak. I
1259 walked to the common room on the ward, sat down and began to
1260 hold my breath. I received another sedative. I was
1261 hospitalized for 2 weeks. The first week is a blurred due to
1262 my mental confusion and the psychiatric medication
1263 administered to me.

1264 However, I do remember some of my experiences. I
1265 interacted frequently with staff and the other patients. One
1266 staff member I felt an affinity toward and spoke with him
1267 frequently. He advised to focus on getting better and to not
1268 come back to the hospital as so many other patients had. My
1269 psychiatrist on the ward diagnosed me with bipolar disorder
1270 and briefly explained that I would be on several medications.
1271 Upon my release from the hospital I found and met with a
1272 psychiatrist in Brooklyn.

1273 During my hospitalization, I accepted my illness and
1274 began my arduous road to recovery. I cannot pinpoint what
1275 triggered my immediate acceptance, but I am grateful it did
1276 not take years for me to obtain insight. Over the course of
1277 my 16-year journey with mental illness, I have simultaneously
1278 embraced my diagnosis and realized that I am more than a
1279 label. I have embraced that I am more than medication,
1280 therapist appointments and support groups. I have learned
1281 that I am not bipolar, I am Hakeem Rahim, and not just any
1282 one piece of my treatment regimen.

1283 At the same time, I have learned that a good treatment
1284 regimen has to be accompanied by positive coping skills,
1285 diet, exercise for brain health, along with spirituality for
1286 spiritual perspective.

1287 The biggest challenge I faced getting to where I am now

1288 was openly acknowledging my mental illness. For so long, I
1289 felt a deep personal shame for having bipolar disorder. This
1290 shame was so entrenched that I even felt uncomfortable
1291 sharing my diagnosis with close friends and even family
1292 members.

1293 In 2012, I decided to speak openly and joined NAMI's In
1294 Our Own Voice program. Through the In Our Own Voice program,
1295 I have shared my story with over 600 people including
1296 individuals living with mental illness and their family
1297 members. Currently, I am the NAMI Queens/Nassau’s Let's Talk
1298 Mental Illness presenter. Through the Let's Talk Mental
1299 Illness program, I have shared my story and provided much
1300 needed awareness to over 4,500 high school students and
1301 middle school students at 37 schools. I see the importance
1302 in and will continue to speak up for mental health and mental
1303 illness education in schools and beyond.

1304 Millions of people in America desire to give voice to
1305 their struggles, but cannot because of the stigma. I am
1306 fueled by the desire to break the silence. I am inspired by
1307 students who want to learn about mental illness to help a
1308 friend or a struggling parent who is hurting. I am
1309 strengthened by people who have decided to out themselves in
1310 an effort to normalize mental illness. Mental illness
1311 education and awareness is essential to combat stigma, end

1312 suffering and to normalize seeking help.

1313 I am grateful to my parents, family and loved ones who
1314 have supported me. I am also grateful for this committee for
1315 picking up this topic as well as this panel because it is my
1316 hope that the ideas put forth today will transform the
1317 already shifting conversation around mental illness, and I
1318 thank you very much.

1319 [The prepared statement of Mr. Rahim follows:]

1320 *************** INSERT H ***************

|

1321 Mr. {Murphy.} Thank you, Mr. Rahim. We appreciate
1322 that.
1323 Dr. Edgerson.

|

1324 ^TESTIMONY OF LAMARR D. EDGERSON

1325 } Mr. {Edgerson.} My name is Dr. LaMarr Demetri Edgerson,
1326 and I wish to thank the chairman and ranking member for the
1327 opportunity to testify today at this very important hearing
1328 on the psychiatric bed shortage. My doctorate is in
1329 psychology. I am a clinical mental health counselor and
1330 licensed marriage and family therapist.

1331 The population we are focusing on today is the
1332 population that I primarily serve in my private practice.
1333 Over the past year, I have served as the Director at Large
1334 for the American Mental Health Counselors Association, also
1335 known as AMHCA. I am here representing AMHCA's 7,100
1336 members. I am also a board member and two-time past
1337 President of the New Mexico Mental Health Counselors
1338 Association.

1339 Clinical mental health counselors are primary mental
1340 health care providers who offer high-quality, comprehensive,
1341 integrative, cost-effective services across the life span of
1342 the individual. We are uniquely qualified licensed
1343 clinicians trying to provide mental health assessment,
1344 prevention, diagnosis and treatment.

1345 I grew up in the welfare system with inadequate health

1346 insurance. Since the age of 18 years I have provided health
1347 care for patients. My career began as an enlisted member of
1348 the United States Air Force where I served for 20 years as a
1349 medic. As a clinical mental health counselor, I now see
1350 children, adults and families in a private practice in
1351 Albuquerque, New Mexico. My specialty is trauma.
1352 Evidence all around demonstrates the Nation's mental
1353 health care system is in crisis. It is generating increasing
1354 demand for inpatient psychiatric beds while simultaneously
1355 decreasing its supply. Because patients have trouble
1356 accessing services in the community, they use the emergency
1357 department for basic and intermediate care. Our current
1358 mental health system still suffers from poor transition from
1359 inpatient institutions to community-based treatment.
1360 In a recent scholarly article, Ms. Nalini Pande
1361 estimated that psychiatric boarding lost nearly $4 million a
1362 year in revenue from service that could have been provided in
1363 lieu of boarding at just one 450-bed teaching hospital here.
1364 Ms. Pande also found that as patients waited, sometimes for
1365 hours, some for days, their psychiatric health deteriorated.
1366 In a patient who often came in with manageable psychiatric
1367 illness subsequently turned into patients with acute needs.
1368 But still, there is more than meets the eye. We at
1369 AMHCA believe some policymakers are going down the wrong path

1370 in addressing the problem of hospital boarding. The barrier
1371 to treatment is accessing timely, effective, quality mental
1372 health service in the community. Surmounting these barriers
1373 requires continuous comprehensive health insurance coverage
1374 that enables access to essential inpatient and outpatient
1375 care, prescription drugs, early intervention, and prevention
1376 programs. All of those essential benefits are provided in
1377 health plans governed by the Affordable Care Act and new
1378 State Medicaid expansion programs, and some are available to
1379 Medicare beneficiaries as well.

1380 We can work smarter to have a better health care system
1381 that systematically reduces crisis situations from
1382 developing. In addition to the importance of State Medicaid
1383 expansion, Medicare mental health services too have never
1384 been fully modernized to include newer providers like
1385 clinical mental health counselors and marriage and family
1386 therapists such as proposed by Representatives Chris Gibson
1387 and Mike Thompson in H.R. 3662. Comprehensive and stable
1388 health insurance coverage is the key to cost-effective,
1389 efficiently, timely mental health services in the United
1390 States.

1391 The new State Medicaid expansion effort has the
1392 potential for millions of currently uninsured Americans with
1393 mental health diagnoses to obtain greatly expanded access to

1394 mental health and substance use treatment in an integrated
1395 community-based setting with a person-centered treatment
1396 focus, the exact objectives, I believe, all policymakers are
1397 trying to achieve today.

1398 Unfortunately, 25 States are refusing to participate in
1399 the new Medicaid expansion program, which will continue to
1400 leave millions of uninsured people with serious mental health
1401 conditions out in the coverage cold. AMHCA believes it is a
1402 huge and costly mistake that Congress under Medicare and
1403 State policymakers under Medicaid have decided to deny their
1404 most vulnerable citizens State health insurance coverage with
1405 comprehensive health care and mental health services.

1406 In summary, Medicare and mental health provider coverage
1407 modernization and State Medicaid expansion will provide
1408 health insurance coverage to millions of people with serious
1409 mental health conditions who have had difficulty accessing
1410 needed and timely service. These changes are necessary to
1411 dramatically reduce the changes of future crisis situations
1412 and increasing emergency department visits.

1413 Thank you again for the opportunity to present this
1414 testimony today before the committee.

1415 [The prepared statement of Mr. Edgerson follows:]

1416 *************** INSERT I ***************

1417 Mr. {Murphy.} Thank you, Doctor. We appreciate that.

1418 Dr. Evans, you are recognized for 5 minutes.

|

1419 ^TESTIMONY OF ARTHUR C. EVANS, JR.

1420 } Mr. {Evans.} Thank you. Mr. Chairman Dr. Murphy,
1421 Ranking Member Representative DeGette and members of the
1422 committee, thank you for inviting me to participate in this
1423 hearing. I am Dr. Arthur C. Evans, Jr., Commissioner of the
1424 Philadelphia Department of Behavioral Health and Intellectual
1425 disAbility services, and I also have a faculty appointment at
1426 the University of Pennsylvania School of Medicine.
1427 I appear here today on behalf of the American
1428 Psychological Association, which is the largest scientific
1429 and professional organization representing psychology.
1430 As the Commissioner of the Department of Behavioral
1431 Health, my job is to ensure that the resources are deployed
1432 to address the needs of 1.5 million people in the city of
1433 Philadelphia.
1434 So today what I wanted to do is to talk as an
1435 administrator, as someone who is trained as both a scientist
1436 and a practitioner, and also a family member myself, and I
1437 want to start by saying I think all of the issues that we
1438 have heard today are solvable problems. I absolutely believe
1439 that. I think we have evidence both in Philadelphia and
1440 around the country that all of the issues that we have heard

1441 today are solvable I think with political will, with
1442 resources and with leadership.
1443 I really appreciate the family members who have
1444 testified today and especially Mr. Rahim, who gave his
1445 personal story, because I think that we have to hear that
1446 people can and do recover, and I want to start my comments by
1447 just giving a few examples of things that I think that we can
1448 do to improve the Nation's mental health systems.
1449 First of all, people can and do recover, and we know
1450 from the research, we know from clinical practice that given
1451 the right resources, given the right types of services,
1452 people can do really well who have even the most serious
1453 forms of mental illness. Unfortunately, our systems are set
1454 up in a way that they don't acknowledge that. We have
1455 systems that are geared towards maintaining people,
1456 addressing people when they are in crisis, and you heard some
1457 of the stories of people who have family members who have a
1458 very difficult time getting help, and the reason that is, is
1459 because of the way we finance our mental health system. It
1460 is diagnostically driven. People either have to have a
1461 diagnosis or to be in crisis. So one of the first issues I
1462 think we have to take on is, how are we financing our
1463 services and are we doing things and are we financing our
1464 service system in such a way that we have the resources to do

1465 outreach and to do early intervention.

1466 Secondly, I think that any discussion around psychiatric
1467 bed capacity has to deal with the efficiency of the current
1468 system. There are a number of things that we can do to
1469 improve the current efficiency, and I will give you a couple
1470 of examples from Philadelphia. We have in Philadelphia a
1471 unit that has people who historically would have been in the
1472 State hospital, very long lengths of stay, numbering
1473 sometimes in the months. We have employed evidence-based
1474 practices, both on the unit and in deploying ACT teams, or
1475 Assertive Community Treatment teams, who have also been
1476 trained up in evidence-based practices, and we are starting
1477 to see a reduction in lengths of stay. I use that as an
1478 example because when we talk about increasing bed capacity
1479 and not addressing the inefficiencies in the current system,
1480 it is not a good use of our resources, and I think we have to
1481 take on those issues.

1482 Similarly, we use a pay-for-performance system because
1483 we believe as a payer that it is really important to have
1484 accountability around the services that are provided. We
1485 have saved over $4 million over a 2-year period simply by
1486 working with our inpatient treatment providers, focusing on
1487 things like continuity of care, making sure that when people
1488 are admitted that if they have a case manager that those

1489 people are coming onto the units, working with people so that
1490 there is a smooth transition. Those kinds of efficiencies
1491 can go a long way in increasing capacity.
1492 I also believe that we have to have a public health
1493 strategy. We cannot have simply a treatment strategy around
1494 this. When people have difficulty getting into services,
1495 sometimes that is because people don't know how to navigate
1496 the system but often it is because there is stigma associated
1497 with mental illness that prevents people from reaching out
1498 for help and so part of our strategies have to be to reduce
1499 stigma and make it more likely for people to reach out for
1500 help. That is one of the reasons that we support things like
1501 mental health first-aid that help people to understand how to
1502 intervene.
1503 Fourthly, I think that we have to think about cross-
1504 systems financing. Many of the issues--if you talk to mental
1505 health commissioners around the country and you ask them what
1506 are the top three issues, I would almost guarantee you that
1507 every single one of them would have housing as one of their
1508 top issues related to the administration of their system and
1509 so as we are talking about this, we have to think not only
1510 about services within the mental health system but we have to
1511 think about other services that people need to be successful.
1512 So with that, I will stop and hopefully we will have

1513 questions that we can talk more about those.

1514 [The prepared statement of Mr. Evans follows:]

1515 *************** INSERT J ***************

|

1516 Mr. {Murphy.} Thank you, Dr. Evans. As we go into
1517 comments here, or questions from Members of Congress, I just
1518 want to have a special thank you for this panel. We have had
1519 a number of hearings and panels on this issue of mental
1520 health, and I recognize members have very busy lives and some
1521 are at other hearings and some are at other hearings and
1522 other areas, but for those members who missed your testimony,
1523 I think their lives are the poorer for it, and to watch how
1524 someone would walk through the system is pretty difficult.
1525 So let me recognize myself for 5 minutes.

1526 Ms. Ashley, your experience you related to us in your
1527 testimony concerning your son's admission and boarding in a
1528 local ER from hours to days, I mean, it is alarming to us.
1529 So were there any other places in the area, were you informed
1530 of any other place in the area where you could have taken
1531 your son instead of having those long delays in the hospital?

1532 Ms. {Ashley.} You mean another emergency room?

1533 Mr. {Murphy.} Yes.

1534 Ms. {Ashley.} Well, my insurance only pays for the
1535 hospital that we went to.

1536 Mr. {Murphy.} Okay. And Dr. Hirshon, in this case, and
1537 we had heard this also, for example, on 60 Minutes when State
1538 Senator Creigh Deeds was talking about his own son, he

1539 couldn't find a place. Is that part of the problem that
1540 occurs too with emergency rooms in terms of getting someone
1541 to--
1542 Mr. {Hirshon.} Yes, the issue of finding an inpatient
1543 facility can be very problematic. You have to find a place
1544 that is going to accept that patient, and historically, there
1545 may have been insurance issues as well. And so, you know, in
1546 Maryland we have tried to device mechanisms to improve this.
1547 One of the things we have now is kind of a central listing of
1548 the hospitals that have inpatient facilities, that have beds
1549 available, but even that is problematic getting the hospitals
1550 to buy into it. So this is a traditional problem, especially
1551 if you have someone who is got a dual diagnosis. Perhaps
1552 they are an adolescent with bipolar and maybe substance
1553 abuse. They can wait--I have had friends had patients weigh
1554 for 13 days in their emergency department looking for a place
1555 to stay.
1556 Mr. {Murphy.} Thank you.
1557 Sheriff Dart, any idea what your total costs per year in
1558 dealing with folks with mental illness in your jail are?
1559 Sheriff {Dart.} You know, Mr. Chairman, that has always
1560 been a difficult number for us to ascertain, but just as a
1561 rule of thumb, it is in the ballpark clearly double, closer
1562 to triple the cost of an average detainee, so we are talking

1563 just tripling every expense that we have there, but the
1564 difficulty where it gets to be sort of quantifying this is
1565 that they come back to us so quickly. So it isn't even as if
1566 you took the one detainee and said okay, he cost more than
1567 the other ones and--
1568 Mr. {Murphy.} You are talking about some of those
1569 costs, $12,000 for pretrial costs and other things with that.
1570 Now, is any of this federal money that is used to help these
1571 patients, these inmates while they are there?
1572 Sheriff {Dart.} No, no, virtually none. It is all
1573 county-related money.
1574 Mr. {Murphy.} Okay. Let me ask also, in this past
1575 winter, I heard about a homeless man who had mental illness
1576 but Washington, D.C., couldn't take him in because it was
1577 only 32 degrees. But once the temperature hit zero, it would
1578 be okay. Is that true, this story that I heard, Mr. Stern?
1579 Mr. {Stern.} Actually, I think Washington did sort of a
1580 heroic job over past years. They had buses, metro buses out
1581 when it got, I think below 15 degrees, and there was
1582 hypothermia in effect under 32 degrees.
1583 Mr. {Murphy.} When I look upon this, and we talk about
1584 somebody being--we are not going to provide help until there
1585 is a crisis, they threaten to kill someone, themselves, or
1586 you had talked about people are not even aware of their

1587 symptoms. In this case, now they are an imminent threat
1588 because they are not even aware of their illness. It is sad
1589 that we have to go to that extent.
1590 Mr. {Stern.} Yes. I mean, the one thing that I would
1591 say is, on the day it got really cold, I went out to the bus,
1592 and there were three people on the bus. I then went under a
1593 bridge nearby and there was five or six people there who
1594 refused to go on the bus, so there is that.
1595 Mr. {Murphy.} Thank you.
1596 Dr. Evans, as you heard these stories about how much is
1597 spent--Judge Leifman talked about this, Sheriff Dart talked
1598 about this, all these other folks. If you had that kind of
1599 money, could you make a difference? I mean, we are spending
1600 it in hospital beds and emergency rooms where they are not
1601 getting treatment. We are spending it in jails. We are
1602 spending it in courts. Could you keep people out of those
1603 systems if Medicaid and other things paid for that kind of
1604 thing?
1605 Mr. {Evans.} There is no question that we can and we
1606 do. For example, in Philadelphia, take the issue of
1607 homelessness. Because we have a mayor that has been pretty
1608 interested in this issue, he has been able to convince the
1609 Philadelphia Housing Authority to make available Section 8
1610 vouchers to my department, which does homeless outreach.

1611 Over the last several years, we have had approximately 200
1612 vouchers a year, and with that, we have been able to get over
1613 500 people off of the streets of Philadelphia who were
1614 formerly homeless, many of whom have serious mental illness
1615 and/or substance use problems, and the way we were able to do
1616 that is to use those housing resources matched with Medicaid-
1617 funded behavioral health care services, and to date we have
1618 about 93 percent of those people are still in stable housing.
1619 So I think that these are solvable issues. I think it takes
1620 creative financing and I think it takes innovations in how we
1621 deliver services.

1622 Mr. {Murphy.} We look forward to hearing some specific
1623 comments from you and others too on what needs to change in
1624 some of the definitions of care so that money can be spent in
1625 helping people, preventing problems and treating them.

1626 I have to ask you, Mr. Rahim, because you have Ms.
1627 Ashley at the table here, who has a son who is a good man but
1628 dealing with schizophrenia, do you have advice for parents
1629 and for other people dealing with this?

1630 Mr. {Rahim.} I believe that Dr. Evans said it best,
1631 that mental illness is treatable and I think a lot of the
1632 panel said mental illness is treatable but I think we have to
1633 have the education to know that it is treatable and that it
1634 is something that you can overcome, and I think having faced

1635 this as well as evidence-based practices will do so much.

1636 Mr. {Murphy.} Thank you. That is a good message of

1637 hope.

1638 Ms. DeGette.

1639 Ms. {DeGette.} Thank you. Let me follow up on that

1640 statement, Mr. Rahim, by you and Dr. Evans.

1641 Dr. Evans, you talked about how evidence-based practices

1642 and lengths of stay can really be used for treatment, and

1643 part of the problem, part of some of these illnesses is

1644 people don't realize that they are ill, and part of it is

1645 stigma. So my question to you is, from what I understand

1646 from what you are saying and others, is that if we can

1647 identify someone with severe mental illness early on and get

1648 them into that treatment, we actually can stabilize their

1649 situation. Is that correct?

1650 Mr. {Evans.} That is absolutely correct, and the

1651 research is pretty clear on this. If you can intervene with

1652 people early, particularly after their first episode, and

1653 there are evidence-based treatments for people who are

1654 experiencing their first episode, you can dramatically change

1655 the trajectory of their illness and significantly improve

1656 clinical outcomes.

1657 Ms. {DeGette.} And I would assume you would agree with

1658 me that probably the way to do that early identification is

1659 not when they present in an emergency room or a jail,
1660 correct?
1661 Mr. {Evans.} That would be correct.
1662 Ms. {DeGette.} And I would assume, Dr. Hirshon, you
1663 would agree with that from an emergency room perspective as
1664 well. That is not the ideal way to identify a severe mental
1665 illness and treat it, correct?
1666 Dr. {Hirshon.} We take care of emergent and urgent, you
1667 know, acute psychiatric problems but my preference would be
1668 not to have to deal with that, I mean, to find support
1669 systems, both inpatient and outpatient, that they don't come
1670 at 3 o'clock in the morning homeless and cold because they
1671 have other place to go, and so yes, I would--
1672 Ms. {DeGette.} And have to find a bed.
1673 And Mr. Dart, you would agree with that from a penal
1674 perspective as well, correct?
1675 Sheriff {Dart.} Oh, absolutely, on two fronts. One,
1676 frankly, during the cold weather, we have people
1677 affirmatively commit offenses so they can come into our
1678 housing. I talk with the detainees on a regular basis. They
1679 will tell me frequently they don't want to leave the jail
1680 because it is the best place they can go for treatment, they
1681 feel safe, they don't get harmed out in the community, and we
1682 have had some where when we release them, they will try to

1683 break back into the jail as a result of that, and
1684 Congresswoman, the one thing that always has troubled me,
1685 when you think about it, each and every one of these people,
1686 we have a full file on them, not only on their criminal
1687 background but their mental health needs. Why we can't
1688 follow them out in simple cast management type of fashion,
1689 and even if we just break the cycle for a short period of
1690 time, we would save tremendous amounts of money.
1691 Ms. {DeGette.} You don't know this, Sheriff, but I
1692 started my career as a public defender, and so I know this
1693 very, very well. I had so many clients in those days who you
1694 could just see they were severely mentally ill, and there was
1695 nothing we could do with them.
1696 Now, I want to ask you again, Dr. Hirshon, I mean, if we
1697 had a better system like one Dr. Evans is talking about to
1698 identify and to treat folks at an early stage, then when
1699 somebody really did have an acute problem, the emergency
1700 system would be better equipped to deal with those folks
1701 because theoretically, there would be fewer of them, correct?
1702 Dr. {Hirshon.} Well, there would be fewer but there
1703 would also be more structure to support them. So a lot of
1704 this is the lack of a kind of systematic structure to support
1705 these people who are either coming in because they have acute
1706 needs or because of their social circumstances. So the idea

1707 to have that improved structure both from a mental as well as
1708 social perspective I think are very critical.
1709 Ms. {DeGette.} Yes, and I want to ask you, Ms. Ashley,
1710 as a fellow mom here, you would much rather--you, as a nurse,
1711 identified that your son had severe psychiatric problems from
1712 an early stage but you didn't have any recourse to get him
1713 the kind of treatment he needed except for continually taking
1714 him to the emergency room. Is that what I hear you saying?
1715 Ms. {Ashley.} Yes, that is right. I worked very
1716 closely with his primary medical provider, who obviously knew
1717 there was something wrong with him, but my son would
1718 continuously deny going to the emergency room to get
1719 psychiatric evaluation. The psychiatric people were even
1720 willing to come to his medical appointment to evaluate him.
1721 That is how tight our community was. And still my son would
1722 say no, he would not go. So I actually had to set up a
1723 situation where he went to the emergency room to get lab work
1724 done and then have him received by the psychiatrist and his
1725 primary medical provider to put him on a hold.
1726 Ms. {DeGette.} Thank you.
1727 Now, Dr. Evans, just if you can briefly tell me, you
1728 have got several projects going on. Where do you get the
1729 funding for those projects?
1730 Mr. {Evans.} So Philadelphia is unique in that the city

1731 manages all of the public sector behavioral health services
1732 that come in. The city is capitated for the entire Medicaid
1733 population so we manage the Medicaid benefit for everyone who
1734 has--

1735 Ms. {DeGette.} So you are getting Medicaid benefits?

1736 Mr. {Evans.} They are getting Medicaid, but we also
1737 receive State, federal, local grant dollars as well.

1738 Ms. {DeGette.} And I just want to finish up with you,
1739 Mr. Rahim. You heard what Ms. Ashley was talking about. Her
1740 son was denying what was happening and she had to sort of
1741 trick him. What do you think about people who get diagnosed
1742 with these diseases? Is it the stigma? Is it the nature of
1743 the disease? And what is your opinion what we can do to get
1744 folks into treatment like you were able to do and to accept
1745 the disease, very briefly?

1746 Mr. {Rahim.} So I have to very much recognize that
1747 mental illness is individual to each person. There are so
1748 many different diagnoses, and each person, even with the same
1749 diagnosis, responds differently to the medication, responds
1750 differently to the knowledge that they may even have it, or
1751 even responds differently to their parents' care and concern.
1752 So I mean, with that--and I do want to acknowledge that. I
1753 am a voice but I am not the only voice, and there are so many
1754 people out there, so I just want to acknowledge that to your

1755 point, that is, it is so different, and it is hard. This is
1756 hard, you know, this is not easy. So even if you have the
1757 care provided, it is still a journey, one, and two, you still
1758 have to recognize that everybody is different.

1759 Ms. {DeGette.} Thank you. Thank you very much, Mr.
1760 Chairman.

1761 Mr. {Murphy.} Thank you. I now recognize the vice
1762 chair of the full committee from Tennessee, Mrs. Blackburn,
1763 for 5 minutes.

1764 Mrs. {Blackburn.} Thank you, Mr. Chairman.

1765 I want to thank each of you for taking the time to be
1766 here and for your willingness to tell your stories, and I
1767 think it is such an important component, and it is important
1768 for us to have your insights as we look at the issue. The
1769 chairman has been on this since day one, and looking for a
1770 way to reach parity and to provide some certainty for those
1771 that suffer from mental illness. So we appreciate that you
1772 are helping us work through this process.

1773 Dr. Hirshon, I want to come to you first. Going back to
1774 the American College of Emergency Physicians 2014 State by
1775 State report card that is out there, and looking at the data
1776 relative to 5 years earlier, and you look at the declines in
1777 the psychiatric beds across the country. Has that been
1778 consistent in your rural, suburban and urban issues? Where

1779 are we seeing the greatest attrition in the number of beds?
1780 Because one of the things we hear from people, especially in
1781 our rural areas, is, they have no access and they don't know
1782 where to turn.

1783 Dr. {Hirshon.} So I would say that each jurisdiction,
1784 each region, each State is different. It is a little hard to
1785 say. But as a general rule, access to care in rural settings
1786 is much more difficult. And the other thing to recognize is
1787 that even if you have insurance, insurance doesn't mean
1788 access because you have to find someone who can take that
1789 insurance and who will be there to give you the services. So
1790 as a general rule, the rural settings and the areas in which
1791 there is fewer services are disproportionately impacted. So
1792 I would agree with that.

1793 Mrs. {Blackburn.} Okay. How do we fix that? How do we
1794 fix that disparity? What do you think? Because the access
1795 is so critical, and as you said, you may have access to the
1796 queue but that does not mean you have access to the
1797 physician, and what we are seeing with the implementation of
1798 Obamacare, the President's health care law. So many people
1799 say well, I have got an insurance card now, and of course, in
1800 Tennessee, we saw this with the advent of TennCare back in
1801 the 1990s but there was nowhere that they could go for the
1802 care or it may be 180 miles away, which is debilitating when

1803 you are trying to access this. So what do you think?

1804 Dr. {Hirshon.} I think again that, you know, not just

1805 psychiatric care but many types of care, you have to look for

1806 creative solutions, and one of the solutions for that is

1807 regionalization of care. So for example, if you have got a

1808 regional center of excellence for psychiatric care, to be

1809 able to utilize that either through telemedicine so they can

1810 do evaluations long distance or in a setting in which they

1811 don't have a psychiatric provider there or there is a way

1812 that you can use that regionalization to help improve the

1813 care I think is one potential model. I think we need to do

1814 research to look for better ways to be able to provide care,

1815 recognizing that our technology--there is an increased demand

1816 but our ability to perhaps meet that demand can be adjusted.

1817 Mrs. {Blackburn.} Okay.

1818 Ms. Ashley, I see you shaking your head. You like the

1819 idea of using the telemedicine concepts?

1820 Ms. {Ashley.} Yes. At UC Davis, we already use

1821 telemedicine for medical diagnoses and so forth, and so I

1822 definitely can see telemedicine with good case management

1823 follow-up definitely would be very helpful to the family and

1824 the consumer.

1825 Mrs. {Blackburn.} So would you classify that primarily

1826 as using the telemedicine concept as an assistance in early

1827 intervention or where would that have the greatest impact?

1828 Ms. {Ashley.} At the very beginning.

1829 Mrs. {Blackburn.} The very beginning, being able to

1830 utilize that.

1831 I have just a couple of seconds left. Dr. Geller,

1832 deinstitutionalization, and you talked about that in your

1833 testimony and you said it was not initiated as a considered

1834 policy but as an accident of history. I want you to expand

1835 on that for just a moment.

1836 Dr. {Geller.} Sure. If you look at the literature

1837 throughout the era, you don't find any literature that talks

1838 about deinstitutionalization before it happened. It was

1839 labeled retrospectively. Some of the downsizing occurred

1840 because of the introduction of psychotropic medications, and

1841 some because of advocacy. But the major incentive for

1842 deinstitutionalization is the IMD rule. The IMD exclusion

1843 means that if I am in a State hospital, my State pays dollar

1844 for dollar for my care. If I am in a community, my State

1845 pays no more than 50 cents on the dollar and may pay as

1846 little as 13 cents on the dollar. So that any State has a

1847 vested interest in moving people from State hospitals to the

1848 community, the cost shift from State tax dollars to federal

1849 tax dollars, and I believe that has been the major incentive.

1850 It was never designed policy.

1851 Mrs. {Blackburn.} So it was done for the money.

1852 I yield back.

1853 Mr. {Murphy.} Thank you. I now recognize Mr.
1854 Butterfield for 5 minutes.

1855 Mr. {Butterfield.} Thank you very much, Mr. Chairman,
1856 for convening this hearing, and thank all of the witnesses
1857 for your testimony today, but more importantly, thank you for
1858 your passion. I understand what mental health is all about,
1859 and I thank you so very much.

1860 I missed some of your testimony but I have been reading
1861 as quickly as I could. Dr. Edgerson's testimony, I have it
1862 in my hand, and it is very interesting and it is very
1863 correct. You dwell on the Medicaid expansion aspect of
1864 health care, and I thank you for raising that because that is
1865 critically important. As most of us know, this committee
1866 wrote the Affordable Care Act. It was written several years
1867 ago, and the Energy and Commerce Committee is the proud
1868 author of that legislation, and as part of that legislation,
1869 it was our intent to expand the Medicaid provision so that
1870 low-income, childless adults could receive the benefit of
1871 health care. We mandated that the States expand their
1872 program, and that part of the law was tested in the U.S.
1873 Supreme Court, and unfortunately, the Court said that we
1874 overstepped our authority, and even though it was a proper

1875 exercise of legislation that we could not compel the States
1876 to expand their Medicaid program, and that was very
1877 disappointing to me. And now 25 States have refused to
1878 participate in that expansion, and my State of North Carolina
1879 happens to one of those States. My State turns down nearly
1880 $5 million per day which could help provide care to those
1881 with mental health issues, and so I am appalled, not only
1882 appalled at my State but the other States that have chosen
1883 not to expand their Medicaid program because we need it.
1884 The Medicaid expansion would not have been a cost to the
1885 States, at least for the first 3 years. All of the costs
1886 would be borne by the Federal Government. Following that,
1887 the Federal Government would pay 90 percent of the cost of
1888 care, and so we have low-income individuals all across the
1889 country who are suffering from mental health issues, from
1890 substance abuse who are not getting the care that they
1891 rightfully deserve.
1892 I live in a low-income community. It is an African
1893 American community in North Carolina, and I can tell you that
1894 mental health and substance abuse issues are pervasive all
1895 across my community. Before coming to Congress 10 years ago,
1896 I was a trial judge, not only in my community but in 32
1897 counties throughout my region. I was one of 10 judges who
1898 presided over the most serious cases in 32 counties, and I

1899 can tell you that we need to extend a hand of friendship and
1900 a safety net for those who are in need. And so I applaud you
1901 for lifting up the whole idea of Medicaid expansion.
1902 Now I get to the question, Dr. Edgerson. I had to get
1903 that off my chest because I understand mental health, not as
1904 much as the 10 of you, but I clearly understand it. I
1905 understand the cost of not treating and detecting mental
1906 health issues, and I know that we would be a better nation if
1907 we just slowed down long enough to recognize the importance
1908 of this issue, and while I am on that, Mr. Chairman, I want
1909 to thank you. I think Ms. Blackburn was correct, that you
1910 have lifted this issue up as a priority of yours from day
1911 one, and I thank you for it.
1912 Dr. Edgerson, it is estimated that 189,000 people in my
1913 State with mental illness would be eligible for Medicaid if
1914 my State would expand Medicaid. How many of the individuals
1915 presenting in the emergency rooms with psychiatric and
1916 psychological issues would have avoided an emergency room
1917 visit if Medicaid had been expanded and they were able to
1918 seek treatment before their disease became a crisis?
1919 Mr. {Edgerson.} I cannot give you an exact number.
1920 However, what generally happens is, if there is not one thing
1921 that we know, we know we can go to the emergency department
1922 if we are having any kind of crisis. A lot of people do not

1923 necessarily have to go to an emergency department because the
1924 crisis can be averted in the beginning, and this is where I
1925 believe that clinical mental health counselors and marriage
1926 and family therapists can come in. So while I may not know
1927 that I have a mental health issue, my friend or my family
1928 member may know, and they may be able to convince me or
1929 persuade me, hey, why don't you go and talk to this person
1930 here and maybe we can help you out, and for me, that is where
1931 the beginning steps are because once I create the
1932 relationship with that patient or client, then they are less
1933 likely to go into a crisis scenario and end up in an
1934 emergency department.
1935 Mr. {Butterfield.} Thank you.
1936 My next question is to you, Mr. Dart, and I heard some
1937 of your testimony earlier, and you talked about some people
1938 believe that jail is the best place for treatment, and you
1939 are absolutely correct. Some in the audience or some
1940 watching on television may find that incomprehensible but
1941 that is a fact in real life.
1942 When I was a trial judge, people would inappropriately--
1943 they didn't know they were being inappropriate--they would
1944 call me at home the night before their loved one was to be
1945 sentenced and they knew that the next day the loved one would
1946 probably be getting out of jail and returning to the

1947 community, and families would literally call me and beg me--
1948 many of them knew me personally. We had grown up together
1949 years ago. They would call and plead with me as a judge not
1950 to release their loved one because they could get better care
1951 and treatment in the facility as opposed to the community,
1952 and they felt that releasing their loved one would be a
1953 danger to the inmate and to the community. So thank you for
1954 bringing that up and reminding me of those days when I was on
1955 the bench.

1956 You have been very kind, Mr. Chairman. Thank you very
1957 much. I yield back.

1958 Mr. {Murphy.} I now recognized the vice chair of the
1959 subcommittee, Dr. Burgess, for 5 minutes.

1960 Dr. {Burgess.} Thank you, Mr. Chairman.

1961 Mr. Rahim, I just have to say, I don't think it was part
1962 of your prepared remarks but your comments about the
1963 individualization of care and the personalization of care,
1964 those words are golden and I hope that everyone on this dais
1965 heard those and will consider them.

1966 Dr. Geller, thank you for your thoughtful chronicling of
1967 the problem. I cannot go back as far as Franklin Pierce but
1968 I did practice medicine in the 1980s and 1990s, not
1969 psychiatry but more in the general medicine realm, but I
1970 remember during that time the vast expansion of psychiatric

1971 facilities that occurred. I am not sure if I know why that
1972 expansion occurred but then as a result of probably actions
1973 by perhaps this subcommittee in April of 1992, a lot of that
1974 was curtailed, and in fact, just researching for this
1975 hearing, there is an article from 1993 that talked about in
1976 one 4-year period the number of psychiatric institutions
1977 doubled, and the graphic they have is 1984 to 1988. This was
1978 a major scandal in the country. A company known then as
1979 National Medical Enterprises eventually entered into some
1980 sort of consent decree with the Department of Justice and
1981 many of the private insurers sued the hospital company for
1982 overutilization or overhospitalization of patients.
1983 So it seems like we went from there where there was too
1984 much activity going on to now where there is not enough. I
1985 can't help but feel the emphasis on administrative pricing
1986 and not paying attention to the individual care that Mr.
1987 Rahim talked about is perhaps responsible, but I think this
1988 subcommittee would do well to remember that it was 20 years
1989 ago where we were talking about a very different problem.
1990 You were probably--I don't want to presuppose, but you were
1991 probably in practice at that time. Is that correct?
1992 Dr. {Geller.} Yes, sir.
1993 Dr. {Burgess.} Do you recall the events that I am
1994 talking about?

1995 Dr. {Geller.} Yes, sir.

1996 Dr. {Burgess.} And what is your observation? I mean,
1997 help us here. You were there, a psychiatrist on the ground,
1998 when this was going on. In your opinion, what is it that
1999 happened that caused that rapid expansion of psychiatric meds
2000 and their overutilization and then the contraction that
2001 followed?

2002 Dr. {Geller.} The expansion that you are talking about
2003 was largely accounted for by private psychiatric hospitals,
2004 generally chain hospitals, that saw an opportunity to make
2005 money quickly. When managed care began to require pre
2006 authorization and the possibilities for admission became more
2007 stringent, those hospitals quickly disappeared. While all
2008 that is happening, the public psychiatric hospitals were
2009 still shrinking, and if I could take a moment?

2010 Mr. {Burgess.} Sure.

2011 Dr. {Geller.} What we seem to not be spending time on
2012 is that we are talking about psychiatric disorders, and while
2013 resources are necessary, ``build it and they will come'' does
2014 not apply to all the people who have psychiatric disorders.
2015 We had a demonstration of that in western Massachusetts. We
2016 had a federal court-ordered consent degree in 1978. Western
2017 Massachusetts, the catchment area, is larger than five of the
2018 States in the United States. At that time western

2019 Massachusetts had more per capita expenditure for mental
2020 health services than any State in the United States and there
2021 wasn't another State that came close. And we still had some
2022 of the same problems.

2023 Dr. {Burgess.} Yes, sir.

2024 Dr. {Geller.} We have a population, some of whom have
2025 something called anosognosia. They don't recognize they have
2026 an illness. You need more than just resources.

2027 Dr. {Burgess.} Let me ask you, Dr. Hirshon, in the few
2028 seconds I have left. I mean, you bought up EMTALA, and as a
2029 practicing physician, I am familiar with that. One of the
2030 great venerable institutions in my neck of the woods,
2031 Parkland Hospital, got into a great deal of difficulty with
2032 their psychiatric emergency room not too terribly long ago,
2033 in fact, put the whole institution at risk because of some
2034 federal regulations that they ran afoul of, but eventually
2035 they went to outsourcing their psychiatric emergency room to
2036 a private hospital facility. In your experience, does this
2037 seem like a--are more hospitals going to be doing this?

2038 Dr. {Hirshon.} My sense is that it is more complicated
2039 than simply a single answer. You have to look at it from
2040 both the patient's perspective as well as the provider's
2041 perspective, and coming up with solutions that allow you to
2042 meet the patient's needs. If it is outsourced in one

2043 jurisdiction, that might work, but again, I think recognizing
2044 that there is a limited number of resources, looking for ways
2045 to more efficiently and effectively utilize those resources
2046 will be key.

2047 Dr. {Burgess.} Thank you, Mr. Chairman. I will yield
2048 back.

2049 Mr. {Murphy.} Thank you. The doctor yields back.

2050 Mr. Tonko, you are recognized for 5 minutes.

2051 Mr. {Tonko.} Thank you, Mr. Chair, and I appreciate
2052 your continued use of this subcommittee to shed light on the
2053 issues related to mental health. For far too long now,
2054 mental health issues have been swept away in the shadows, so
2055 anything we can do to raise the profile and reduce the stigma
2056 associated with mental illnesses is a very worthy endeavor
2057 indeed.

2058 As amply demonstrated today, the lack of available
2059 psychiatric beds, particularly in time of crises, can be a
2060 pressing issue. For example, we all witnessed the tragedy
2061 that occurred in neighboring Virginia when State Senator
2062 Creigh Deeds was unable to locate an available bed for his
2063 son in time. However, we also all share a goal of
2064 deescalating in treating these types of situations before
2065 they do reach the stage where a patient requires hospital-
2066 based care.

2067 So with that in mind, Dr. Evans, from your experience,
2068 how can we improve our mental health delivery system in a way
2069 that reduces the demand factor for inpatient psychiatric
2070 care?

2071 Mr. {Evans.} Thank you for that question. I think
2072 that, you know, any discussion about psychiatric bed capacity
2073 focuses on expanding bed capacity, and I think that is a
2074 trap. Prior to being in Philadelphia, I was also the Deputy
2075 Commissioner in the State of Connecticut, so the past 15
2076 years I have been in administrative positions that have to
2077 make decisions about how resources are deployed in a mental
2078 health system, and I can tell you that the fundamental issue
2079 is that we have to build a very strong community-based
2080 system. That is the fundamental problem. Psychiatric bed
2081 capacity is only a symptom of a deeper problem, and I think
2082 you hear the testimony of all the people here, they talk
2083 about the difficulty when it is clear that a family member or
2084 even a person is having a problem. Well, there are not the
2085 resources to do the kind of outreach to individuals when they
2086 are at that point, and the way we finance our service system,
2087 we have to wait until people are at a crisis point, and you
2088 know, that is not only the problem of the mental health
2089 systems but it really has to do with the fact that unless we
2090 create the kind of flexibility where mental health systems

2091 can do the kind of assertive outreach, we are going to
2092 continue to have this problem.
2093 I remember, maybe it was Dr. Geller that said, you know,
2094 one of the problems with mental illness is that often people
2095 don't recognize that they have a problem, and if people don't
2096 recognize that they have a problem, you can build as many
2097 beds as you want, people are not going to get there unless
2098 they are forced into those beds. The solution is to have
2099 resources in the community where people can--for example, in
2100 Philadelphia, we have mobile crisis teams that can go out and
2101 reach out to people before they are hospitalized. Those
2102 kinds of services I think are critical.
2103 Mr. {Tonko.} Thank you. And so as you build that
2104 infrastructure and that holistic response, Dr. Evans, what is
2105 the appropriate way to measure the amount of inpatient beds
2106 that would be required in a given community?
2107 Mr. {Evans.} I think that that is a very difficult
2108 question to answer, and people have used things like
2109 population and so forth. The reality is that it depends on
2110 how your service system is structured. If you have a service
2111 system that has resources on the front end, for example, in
2112 Philadelphia, we have a network of five crisis response
2113 centers, so we don't have the problem of people going to
2114 emergency departments who are in psychiatric crisis, not to

2115 the extent that you have in other cities. We have a mobile
2116 crisis team that can do outreach, and so in Philadelphia that
2117 might look different than another system that might be
2118 similarly resourced in terms of the amount of money but
2119 doesn't have those kinds of services.

2120 I think the issue is, we have to build a very strong
2121 community-based system that prevents people from going into
2122 crisis and we have to have the services so that when people
2123 come out of those beds, that we are able to help them in
2124 their process of recovery, we are able to help them to
2125 stabilize and we are able to do things like helping people
2126 get supported employment or to use supported employment, for
2127 example, which dramatically decreases hospitalization. So
2128 those kinds of community-based services are really important
2129 in terms of the capacity that you need.

2130 Mr. {Tonko.} Thank you. And Dr. Geller, in your
2131 testimony you rely heavily on the fact that State investments
2132 in mental health have been predicated upon where they can
2133 shift most of the cost to the Federal Government. In your
2134 opinion, how could we address the Medicaid IMD exclusion
2135 without leading to a disinvestment by our States' mental
2136 health services?

2137 Dr. {Geller.} That is an excellent question. In my
2138 testimony, I mentioned that the Federal Government should

2139 offer the IMD exclusion waiver to States, requiring a
2140 maintenance of effort. The American Psychiatric Association
2141 has a position statement that is rather specific on this--I
2142 could certainly provide it to you--that indicates that a
2143 State who took such a waiver would be required to continue
2144 its expenditure as averaged over the past 5 years from all
2145 sources that they spent previously. That is not just the
2146 department of mental health but the department of children's
2147 services, department of corrections and so on and so forth.
2148 If there was a requirement for maintenance of effort, there
2149 couldn't be a reverse shift.

2150 Mr. {Tonko.} Thank you. I agree with that maintenance
2151 of effort, so thank you very much, and again, to the entire
2152 panel, your testimony is very much appreciated.

2153 Mr. {Murphy.} I now recognize the gentleman from
2154 Virginia, Mr. Griffith, for 5 minutes.

2155 Mr. {Griffith.} Thank you, Mr. Chairman.

2156 First, Dr. Geller, if you could provide that information
2157 to me as well that you were just talking about?

2158 Dr. {Geller.} Yes, sir.

2159 Mr. {Griffith.} It is very interesting. I found your
2160 testimony and everybody's testimony very informative.

2161 Mr. Chairman, I appreciate you having these hearings. I
2162 have to say that I don't understand mental illness. It

2163 worries me because I don't, and it is one of those areas
2164 where I least like these hearings that the chairman has
2165 called because normally I have a pretty good idea of where I
2166 think we ought to go when it comes to these mental health
2167 illnesses. I have to confess that I am learning something
2168 every time we have a hearing, but I am also concerned that I
2169 don't think that we have all the answers or that we have any
2170 idea what all the answers are, so I appreciate you all
2171 helping us try to figure that out. As representatives of the
2172 people, it is interesting because we are all trying, I think,
2173 Democrats and Republicans on this subcommittee, to figure out
2174 what we can do to make the situation better.
2175 I don't, however, believe that in the short term we are
2176 going to be able to make huge differences because we are
2177 going to have to do some trial and error. We are going to
2178 have to try to do some new things and some different things,
2179 and I appreciate that.
2180 In that regard, I guess I will look to Mr. Dart and to
2181 Judge Leifman. How can we make the court system better? We
2182 are not going to overnight say okay, none of the folks with
2183 mental illnesses are going to come into the court systems,
2184 but what can we do to make the court system better? You have
2185 heard from Ms. DeGette, who has a public defender background,
2186 and Judge, now Congressman Butterfield. I was a criminal

2187 defense attorney for 27 years, and I have to commend one of
2188 my judges back home. He hasn't set up a mental health court
2189 but has a mental health docket where she deals with folks who
2190 have those issues and tries to identify those in advance so
2191 that they can have the experts present to help on that.
2192 But what types of things can we do to encourage the
2193 States and the federal system to do a better job? Until we
2194 fix it, what can we do to help out in the court systems?
2195 Sheriff {Dart.} Thank you, Congressman. I will be
2196 quick, because Judge Leifman and I have talked before about
2197 these things.
2198 Getting the courts more engaged is imperative. In our
2199 court system, they have been completely disengaged. Whenever
2200 you ask them about solutions, they say well, we have a mental
2201 health court so it is done. Their mental health court
2202 usually handles about 150 cases total a year. I usually have
2203 about 3,500 mentally ill in my jail in a day. So we can't be
2204 diverted when people have programs that are inherently good
2205 but aren't getting at the heart of the problem.
2206 What we have been doing internally is trying to identify
2207 people literally as they are dropped off from being arrested
2208 the night before, downloading quickly their information on
2209 their mental illness, and then we put a file together for the
2210 public defender. I a former State's attorney. We put a file

2211 together for the public defender to plead with the judge that
2212 this person is not necessarily a criminal, put them in an
2213 alternative setting such as a nursing home setting. We have
2214 been doing that at my jail where I put electronic bracelets
2215 on their legs, I monitor them at this setting. The results
2216 are fantastic, as you can imagine, compared to what the other
2217 treatment would be, which is, I put them in a four by eight
2218 cell with a complete stranger with their own issues as well.
2219 So we have been doing that, and then on the back end, we
2220 have been pretty much winging it, and that is why,
2221 Congressman, when you talk about trial and error, that really
2222 is the route that we have been going. It can't get any worse
2223 than it is now so let us try some new things. So on the back
2224 end what we have been doing is, we are putting together case
2225 plans for them. We drive them to locations where we
2226 potentially can get housing for them so they can be there and
2227 be stabilized, and then we run a 24-hour hotline when they
2228 are in crisis to get out to them to help them. But it is
2229 just what you said, Congressman. We are at a trial-and-error
2230 stage right now but there are things such as that that
2231 certain judicial circuits could be doing. Others are better.
2232 Ours is a real struggle.
2233 Mr. {Griffith.} Judge?
2234 Judge {Leifman.} Thank you for your question. We have

2235 created an organization called the Judges Leadership
2236 Initiative with a parallel organization called the
2237 Psychiatric Leadership Group, and we are working with the
2238 American Psychiatric Foundation, and what we are doing now
2239 is, we have about 400 judges involved in this operation and
2240 we are going around the country. We have developed a
2241 curriculum to teach judges how to identify people in court
2242 who may have a serious mental illness, how to deescalate a
2243 situation in court so they don't make it worse, but more
2244 importantly, how to work in the community to set up the kind
2245 of supports you need to be able to divert this population,
2246 and so what we recommend are a couple things. A pre-arrest-
2247 type diversion where you work with law enforcement to teach
2248 them a program called crisis intervention team policing where
2249 the police are actually taught how to deescalate, where to
2250 transport and how to avoid an arrest. Our statistics are
2251 phenomenal. As I mentioned, we have closed a jail as a
2252 result of our CIT officers in Dade County. We have also
2253 taught them to set up post-arrest diversion programs so that
2254 you take low-level offenses that don't need to be in jail or
2255 felonies that are nonviolent and you make sure that they get
2256 access to treatment.
2257 Sheriff Dart is correct. The mental health court only
2258 handles a fraction of the cases, and the data is such that

2259 unless they are taking the right people, they actually can do
2260 more harm than good, so you have to be very careful and you
2261 have to be educated.

2262 Mr. {Griffith.} And Mr. Chairman, I know I am out of
2263 time but could we give Chief Biasotti--I know I mispronounced
2264 that. I apologize. But could we give the chief a moment to
2265 comment on that as well?

2266 Mr. {Murphy.} Yes.

2267 Chief {Biasotti.} I would say our main concern law
2268 enforcement-wise are the seriously mentally ill group that
2269 are unaware of their illness. I mean, that is wherein the
2270 problem lies for us. The police departments, your county
2271 directors know who these certain group of people are because
2272 we deal with them every day, and there is answers that we can
2273 deal with that.

2274 In a case that we had not long ago, we had a woman
2275 severely mentally ill, went into a house, no one was home,
2276 took the pit bull and put it in a closet, went upstairs, took
2277 all the clothing out of the woman's clothes, put her dishes
2278 from upstairs downstairs, moved all the pictures, spent the
2279 day. The woman came home--the homeowner--and walked in on
2280 her and of course, you know, had a cow right then and there,
2281 called the police. The police come, and she was totally out
2282 of her mind, psychotic, carrying on. So when I arrived at

2283 the police station on a different matter, I heard this
2284 screaming coming from our booking area. She was in the
2285 booking area, you know, voices were talking to her and she
2286 was complaining she was being raped by whatever at the time
2287 while she is sitting there. So I made a decision at that
2288 point, which a lot of people don't do, but being familiar
2289 with this topic I said listen, we are not arresting her for
2290 burglary. I said she is going to go to the psych unit but I
2291 am going to send a letter with her saying that she is
2292 obviously dangerous. She could have been killed. Whoever
2293 came home could have shot and killed her is most likely to
2294 happen. I said if we arrest her, she is going to go to the
2295 county jail, she is going to be a major problem for them.
2296 From there our officers are going to go out to grand jury
2297 where they are going to move to indict her for whatever. She
2298 will be in jail for a year before they decide that she is so
2299 mentally ill that she can't stand trial, and then she will be
2300 back here again. I said so let us get her into the system
2301 now and put her through that service. But I accompanied that
2302 with a letter to our county mental health director saying I
2303 strongly suggest that, you know, she is proven to be
2304 dangerous, she has a long history, to herself, mostly; I
2305 suggest that you enter her into the assisted outpatient
2306 treatment program. This program, they provide the services

2307 to her through this program. She has not been a problem
2308 since. They monitor her, make sure that she is in some kind
2309 of treatment, and as long as she is in treatment, she is not
2310 a problem. However, if we went the legal system as we
2311 normally would do, we would be dealing with her every few
2312 weeks because she has anosognosia, she does not believe she
2313 is ill.

2314 And I know, you know, stigmatism is a big concern, and
2315 my wife and I both pray for the day that our daughter has the
2316 insight that Mr. Rahim has into her illness because I believe
2317 if she had that insight, she could seek what everybody is
2318 talking about, care in the community. It has been 20 years
2319 almost and she does not have that insight. She has voices,
2320 and they are, as she is concerned, a supreme being.

2321 Mr. {Griffith.} I hate to cut you off but my time is
2322 way over.

2323 Chief {Biasotti.} I am sorry.

2324 Mr. {Griffith.} That is all right. No, I appreciate
2325 the testimony.

2326 Thank you, Mr. Chairman, and I yield back.

2327 Mr. {Murphy.} That was valuable because New York, as I
2328 understand, has actually reduced their incarceration rates
2329 and homeless rates, I think by 70 percent. It has been a
2330 massive savings.

2331 Chief {Biasotti.} That is correct, through AOT.

2332 Mr. {Murphy.} Thank you. Ms. Schakowsky, you are
2333 recognized for 5 minutes.

2334 Ms. {Schakowsky.} Well, I am so glad I got here because
2335 I wanted to say a special welcome to my great friend, Sheriff
2336 Tom Dart. We were seatmates for a while in the Illinois
2337 General Assembly. And I wanted to really talk to you about a
2338 problem I know you are struggling with so much.

2339 The New York Times article ``Inside a Mental Hospital
2340 Called Jail'' really focused on the largest mental health
2341 center in America. It is a huge compound here in Chicago
2342 with thousands of people suffering from mania, psychosis,
2343 other disorders, all surrounded by high fences and barbwire.
2344 That is the county jail.

2345 So I wish you would just briefly discuss how cuts to
2346 mental health programs and services have affected individuals
2347 with mental illness that are now in your custody.

2348 Sheriff {Dart.} Thank you so much, Congresswoman, and
2349 it is great seeing you again.

2350 You know, you almost don't know where to start because
2351 up until about 5 years ago, the normal process in our jail 5,
2352 6 years ago and, frankly, from my understanding, in most
2353 jails around the country now, when you get that court order
2354 to release somebody, you release them. The court is ordering

2355 their release and you have got to let them go, so you let
2356 them go. What we were seeing is out in front of our jail,
2357 there were people that just wandered around, stayed there,
2358 and as I had mentioned earlier, we have people trying to
2359 break back in. One threw a planter through a window to crawl
2360 back into the jail, and then we had to arrest him.
2361 The reality of it is, is that when we were releasing
2362 people, they had nowhere to go, and in the face of that, in
2363 our State we have made tremendous cuts, I mean, just over the
2364 last 10 years. We are one of the leading States in cutting
2365 mental health funding, period, and in the city of Chicago, we
2366 just cut in half our clinics in the community. So when the
2367 people leave, not only do they have nowhere to go, there was
2368 no plan whatsoever, and as I had referenced earlier, I do
2369 think this is doable with not great expenditures because we
2370 literally have everything about this person in our
2371 possession. So if you are trying to think of case plans and
2372 diagnosing them and what would be the best strategies, there
2373 is a myriad of things we can do, but when you have no place
2374 for them to go--I used to hand out a resource book in my
2375 first couple of years as sheriff to give people a place to
2376 go. I had to stop doing that because everything in it was
2377 wrong because most of the things that we were trying to steer
2378 people toward were all closing, and so we were then setting

2379 them up to fail because there was nothing really out there.

2380 And so the cuts that are so tremendous, it has left all
2381 the locals including ourselves trying to devise unique,
2382 creative strategies on what to do including, as I say, I will
2383 drive people now. If I can find homes for them, we will
2384 drive them there. I mean, I will contact their family
2385 members ahead of time to get them to come pick people up, and
2386 mind you, we are happy to do this, but I don't think in
2387 anyone's estimation sheriffs should be doing this. We are
2388 supposed to lock people up, and that is really sort of
2389 supposed to be the end of it, but there is nothing else out
2390 there, and in our county in particular, it has really been
2391 bad, and it is desperate, and it is really heartbreaking. I
2392 talk with the detainees frequently, and do we have bad people
2393 in the jail who have committed offenses who are mental
2394 illness? Yeah, we have those. The vast majority of them,
2395 though, are good people who are suffering from mental illness
2396 and the reason they are there is because of the mental
2397 illness. It is not because they are a criminal, and yet we
2398 treat them like criminals, they are housed with criminals,
2399 and then when we leave them, we basically pat them on the
2400 back and say good luck and we will see you soon, and then we
2401 are all puzzled that they are back with me.

2402 Ms. {Schakowsky.} So it is not just a matter then of

2403 driving them to a place. It is that at the end of the day
2404 there is no place for many of them, right?
2405 Sheriff {Dart.} There is no place for them, and there
2406 is no one to work with them because they need a certain level
2407 of case managing to make sure they stay on their meds, that
2408 when they do go into crisis they are not left to doing what
2409 is going on right now, which they call myself and my staff
2410 and we try to figure out what we can help them with. There
2411 are things that we can do that will not be expensive that can
2412 help and it be a continuum of care. It could work with
2413 people. It won't be 100 percent successful but it can't
2414 conceivably be any worse than what we do now.
2415 Ms. {Schakowsky.} And what are those simple things?
2416 Sheriff {Dart.} Oh, upon leaving the jail, if I had
2417 someone from a county agency, State agency that would
2418 literally be their case manager who would just literally work
2419 with them through housing issues, staying on their meds so
2420 that they don't start self-medicating which is, you know, no
2421 surprise that we are having this heroin epidemic in our
2422 county because it is the next best thing to their meds is the
2423 heroin and so cheap these days. They stay on their meds.
2424 Housing--there is some housing available. It is not the best
2425 but it is not that expensive. I was paying for housing out
2426 of my own budget but I have run out of money now. So as

2427 Judge Leifman said, if we had a continuum working with the
2428 medical side but also with the judiciary, we could have
2429 something that could be somewhat of a model for a lot of
2430 people and not that expensive.
2431 Ms. {Schakowsky.} Thank you very much, and thanks for
2432 what you are doing.
2433 Sheriff {Dart.} Thank you so much. It is great seeing
2434 you.
2435 Mr. {Murphy.} I just want to follow, Sheriff Dart. You
2436 heard Chief Biasotti talk about New York has assisted
2437 outpatient treatment where they make sure, as long as that
2438 person has been shown to be a safety risk or they have had an
2439 episode of violence or jail time before, they can work with a
2440 judge and they work on an agreement to stay on their
2441 medication and get in treatment. Now, I understand you don't
2442 have that in Cook County. Am I correct?
2443 Sheriff {Dart.} No. We just had some intervention just
2444 literally days ago from our State Supreme Court to try to
2445 rearrange and help our local judiciary in doing their job,
2446 but we have not had engagement from our judiciary. I will be
2447 honest with you: you need an enlightened judiciary who
2448 clearly understands the distinction between criminal law and
2449 mental illness and know that there is other paths to go.
2450 Because otherwise you are left with, frankly, Mr. Chairman,

2451 isolated judges who get it, who will run certain courts and
2452 frankly take risks. We for years now, as I say, have been
2453 putting all these files together to hand to the public
2454 defender to just show the mental health background here, the
2455 lack of criminality, and yet they go up and they might as
2456 well be talking in a foreign language to the judge. The
2457 judge does the same thing. They throw them in the jail and
2458 we continue to do the same work.

2459 So an enlightened judiciary that is engaged with it, and
2460 it does happen in other jurisdictions. It would be
2461 absolutely remarkable. It would save money.

2462 Mr. {Murphy.} Thank you. Mrs. Ellmers, you are
2463 recognized for 5 minutes.

2464 Mrs. {Ellmers.} Thank you, Mr. Chairman, and again,
2465 thank you to the panel. This is one of those situations
2466 where I have questions for every one of you, but
2467 unfortunately, we don't have enough time for that, so I will
2468 try to stay focused to the point of how we can as legislators
2469 help this issue and try to focus on those areas where we
2470 think there is the greatest need, at least to get it started,
2471 because Mr. Dart, as you have pointed out, we are in a pretty
2472 bad place right now so anything we do is going to improve the
2473 situation, and I am very concerned about those who are being
2474 released from jail and, you know, not able to continue their

2475 treatment, because as you have pointed out, it is just
2476 cyclic, and Mr. Biasotti as well.
2477 Ms. Ashley, I do want to go back to one of the issues
2478 that has been raised, and I know we are discussing medical
2479 coverage. I know some of my colleagues are saying if we just
2480 had a bigger Medicaid system, that that might actually help
2481 the situation. You know, obviously you know we are dealing
2482 with that every day here, trying to make our health care
2483 coverage system work better. If I remember correctly from
2484 your testimony and previous questions, you said you have
2485 private insurance that your son was able to receive treatment
2486 under. Is that correct?
2487 Ms. {Ashley.} Yes, it is. I have him as a disabled
2488 adult under my insurance.
2489 Mrs. {Ellmers.} Okay. So you actually have insurance
2490 coverage but still had the difficulties. It wasn't just an
2491 issue of here is my insurance card, therefore I am going to
2492 get mental health services for my son?
2493 Ms. {Ashley.} Right. In fact, he is denied some
2494 services in the community because he does have private
2495 insurance.
2496 Mrs. {Ellmers.} I see. Okay.
2497 Ms. {Ashley.} Even though he has SSI and Medi-Cal, they
2498 have no way to bill the insurance to get it denied and then

2499 go on Medi-Cal, so I don't even have access to a lot of the
2500 support services that are available in my community because
2501 he is on private insurance, and people have even told me to
2502 take him off private insurance, and really, having private
2503 insurance is what gets him hospitalized quickly because the
2504 lights go off when they see that I have private insurance
2505 versus Medi-Cal or Medicaid.

2506 Mrs. {Ellmers.} I see. Now, to that point, one of the
2507 things that I was wondering, when you were describing your
2508 situation in the emergency room, and I have seen this in so
2509 many hospitals where they literally brought me to the
2510 designated area in the emergency room that they have
2511 literally put together because of this situation so that they
2512 can give the best treatment possible but they are still
2513 hampered because they are obviously not a psychiatric unit,
2514 and they are dealing with the situation. Was he able to at
2515 least start receiving mental health treatment while he was
2516 there in the emergency room? I mean, was that pretty much at
2517 a standstill until he received the psychiatric bed?

2518 Ms. {Ashley.} Right. He was put in four-point
2519 restraints and heavily sedated until they transferred him to
2520 the hospital.

2521 Mrs. {Ellmers.} Okay. And you did mention that, so I
2522 thank you for that. And again, that is an area we are trying

2523 to fix. You know, there are so many pieces and parts to this
2524 issue.
2525 Mr. Biasotti, one of the things that I would like to
2526 clarify even just for committee is the difference between
2527 civil commitment and forensic commitment, if you can answer
2528 that question, because I think that will help us as well
2529 because I think sometimes we do find ourselves again
2530 struggling with the situation of those who do not acknowledge
2531 that they have a problem and yet they are having a psychotic
2532 episode.
2533 Chief {Biasotti.} And that is where the problem lies.
2534 The police will bring the person from their home or from
2535 wherever the instance occurs to the emergency room, usually
2536 against their will, under a State code for imminent
2537 dangerousness and then they are relying on the interview at
2538 the hospital for the psychiatrist to make a determination
2539 that they meet the standards to hold for a 72-hour period for
2540 evaluation for commitment under that standard. So I think
2541 Dr. Geller could probably help me with the difference between
2542 the civil--I am more familiar with how we would do it.
2543 Mrs. {Ellmers.} Dr. Geller, would you like to expand on
2544 that then?
2545 Dr. {Geller.} Sure. Every State has its mental health
2546 act, and that allows people to be civilly committed, usually

2547 on a standard of dangerous to self, dangerous to others or
2548 gravely in need of care, and there is no crime involved.
2549 Forensic commitment would mean that a person has been charged
2550 and booked and then they are going to be committed usually
2551 initially for a determination of competency to stand trial,
2552 criminal responsibility, or both, that you heard about
2553 earlier. If they cannot stand trial or are found not guilty
2554 by reason of insanity, then they can be further committed
2555 under a criminal statute of that State.

2556 Mrs. {Ellmers.} And yes, Dr. Hirshon?

2557 Dr. {Hirshon.} I think it may State by State but in my
2558 State, what happens is, there is a fixed number of inpatient
2559 beds, and these individuals who are on forensic, not the ones
2560 who have been convicted but they are often the pretrial folks
2561 will be taking up the beds that I will be looking for from
2562 the emergency department. So it doubly impacts it because it
2563 then backs up my system because the forensic folks are being
2564 housed in that situation.

2565 Chief {Biasotti.} And if I could add, from a law
2566 enforcement aspect, most of the people that we are talking
2567 about we are bringing in not because of crimes, we are
2568 bringing them in just because of bizarre activity or
2569 dangerousness. The criminal aspect, we would have to make an
2570 arrest and it would go through the jail system and they would

2571 arrange for psychiatric evaluation.

2572 Mrs. {Ellmers.} And Judge Leifman, I think you look
2573 like you wanted to indicate, and I realize I have gone over
2574 my time but I would love to hear from you.

2575 Judge {Leifman.} What is happening is, the forensic
2576 beds are actually taking over the civil beds, because it is
2577 constitutional, because if you are arrested on a felony
2578 generally and you are incompetent to stand trial, you have to
2579 go--

2580 Mrs. {Ellmers.} To a--

2581 Judge {Leifman.} --for competency restoration. So as
2582 the States don't want to expand those budgets, they just
2583 start to use the civil beds for forensic beds. So it is
2584 really creating this horrible pressure.

2585 Mrs. {Ellmers.} I see. Well, thank you all, and Mr.
2586 Rahim too and Ms. Ashley for your personal stories. It is so
2587 important for us to hear because we need to understand how we
2588 can deal with this situation better, and again, thank you to
2589 all of you. This has been a very, very good subcommittee
2590 hearing, and I am hoping that we will really be able to fix
2591 this problem. Thank you.

2592 Mr. {Murphy.} Thank you, Mrs. Ellmers. I now recognize
2593 Mr. Harper for 5 minutes.

2594 Mr. {Harper.} Thank you, Mr. Chairman, and thank each

2595 of you for being here and helping us, and we hope in the
2596 process we will be able to look at some suggestions and
2597 directions and things that may help you.
2598 Chief Biasotti, if I could ask you, you know, you have
2599 described obviously law enforcement being the front line on
2600 counteracting the impacts of serious mental illness in the
2601 community. What kind of burden is this on your resources and
2602 your department?
2603 Chief {Biasotti.} Well, that is the problem. That is
2604 what my paper focused on, and it was that most police
2605 agencies are very small in this country. The big cities are
2606 the anomalies. So for instance, in my department, which is
2607 considered midsized with an authorized staff of 50 officers,
2608 we will have three or four cars per shift, a minimum of three
2609 on the road per shift. So normally when we deal with a
2610 severely mentally ill person who is acting violent, it
2611 requires at least two of our officers. So that is two out of
2612 three people available. Now we have one officer for a
2613 municipality, a good-sized municipality, until those officers
2614 are free. A lot of times the ambulance can't take them
2615 because they are too combative and the hospital wants you to
2616 stay with them while they are in the emergency room until
2617 they make a determination as they are staying, which is
2618 because if they decide they are not staying, they don't want

2619 this psychotic person in their lobby and you need to take
2620 them back to where you came from. So it is a great depletion
2621 of resources for law enforcement nationwide, especially those
2622 in the rural areas.

2623 Mr. {Harper.} You know, I actually was a city
2624 prosecutor for about 6 years before I came here, and that was
2625 always the thing, and I appreciate what you said you do
2626 because sometimes you know they don't need to be
2627 incarcerated; they need to get help. Because not every
2628 department does it that way. So I want to commend you for
2629 that.

2630 Chief {Biasotti.} Well, it is difficult because you
2631 also have a crime victim that doesn't understand why the
2632 person that broke into their house is not going to jail, so
2633 you have to have cooperation on a lot of levels. But also to
2634 that end, what I wanted to bring up quick is, I got to work
2635 with Governor Cuomo's office in the SAFE Act, the back end,
2636 Kendra's Law, and one thing that I think we are hopeful is
2637 going to make a change is, one of the changes in Kendra's Law
2638 mandates that in prison settings, those who are receiving
2639 psychiatric care in the prison will be evaluated upon release
2640 for inclusion into an assisted outpatient treatment program,
2641 which hadn't happened before. Before that, your time is up
2642 and you're out the door and there goes your treatment. So we

2643 are hoping that that is going to make changes and lessen
2644 recidivism.
2645 Mr. {Harper.} Thank you very much.
2646 Dr. Evans, I was looking at your title as we were going
2647 here, and I am also seeing what Ms. Ashley has gone through
2648 on a personal level, and what you have too, Chief. I have a
2649 24-year-old son with fragile X syndrome, so he has
2650 intellectual disabilities. So how do you distinguish
2651 between, you know, classic mental illnesses or someone with
2652 an intellectual disability that someone who is not trained
2653 may not recognize? Give us some wisdom or advice. What do
2654 you--how do you handle that?
2655 Mr. {Evans.} Sure. So the easy way to make the
2656 distinction is that if a person has an intellectual
2657 disability, that is pretty much permanent. So those kinds of
2658 disabilities are lifelong, and our goal there is not
2659 necessarily recovery but it is really to help people have a
2660 high quality of life, to have self-determination. Mental
2661 illnesses are treatable, and one can have a very severe
2662 mental illness, schizophrenia, for example, bipolar illness,
2663 and can recover and can do well. It doesn't happen all the
2664 time but the majority of the time and so that is really the
2665 distinction. We work with people differently based on that.
2666 Mr. {Harper.} You know, with my son, if he were out by

2667 himself, if he was maybe in a sensory overload moment, it
2668 might be misinterpreted as to what he has, so training and
2669 understanding and realizing that every case, every person is
2670 different I know is an important thing for you.

2671 Mr. {Evans.} It is, and I think that educating the
2672 community about mental illnesses and intellectual
2673 disabilities I think is a real important part of this because
2674 you have heard the impact that stigma has on people reaching
2675 out for help, on the shame that comes with that, and I think
2676 that our strategies have to not only include how do we change
2677 the service system but like we have done with other illnesses
2678 like cancer. You know, 30, 40 years ago, people used to
2679 whisper that and now people have marches about that and walks
2680 about that, and I think it has changed how people reach out
2681 for help when they need it. It has changed how we fund
2682 research and treatment. And I think the same thing applies
2683 to mental illness and behavioral health conditions.

2684 Mr. {Harper.} Thank you, Dr. Evans, and thanks to each
2685 of you. Mr. Chairman, I yield back.

2686 Mr. {Murphy.} Thank you. Dr. Burgess asked, we have
2687 two items here from the New York Times and from Freedom
2688 magazine regarding some cases from 1992 and 1993 that he
2689 would like to have submitted into the record, so without
2690 objection.

2691 [The information follows:]

2692 *************** COMMITTEE INSERT ***************

|

2693 Mr. {Murphy.} And Ms. DeGette, you have a clarifying
2694 question?
2695 Ms. {DeGette.} I just have a clarifying comment, Mr.
2696 Chairman, and I just want to say again, I have been on this
2697 subcommittee for 18 years, and this is, I think, maybe the
2698 best panel we have ever had, so thank you all for coming.
2699 You have practical solutions. You had different takes on the
2700 mental health system, and I hope that each of you will be
2701 willing to make yourselves a resource to the chairman and
2702 myself as we move forward in our efforts.
2703 Chief, you referred to Kendra's Law, and I just wanted
2704 to put in the record what that is, so you can correct me if I
2705 am wrong. I understand what this is. It is a law that was
2706 passed in New York that establishes more structured treatment
2707 combined with resources across the mental health system, and
2708 it is designed to get treatment to folks earlier on without
2709 having them participate in the penal system like Sheriff Dart
2710 was talking about or in the emergency room system. It is
2711 designed to get them treatment. But of course, you have to
2712 have an investment to do that of resources.
2713 The chairman and I were up here talking about this, and
2714 if you did have this investment of resources and you were
2715 really able to implement things like this, it would actually

2716 probably save money because you wouldn't be putting these
2717 people in incarceration or in very expensive ER situations.
2718 Every single person here is nodding their head. I would like
2719 to just say that for the record.
2720 Thank you very much.
2721 Chief {Biasotti.} If I can say, the shame of it is, we
2722 have 45 States that have a very similar law but very few use
2723 it.
2724 Ms. {DeGette.} Because they are probably not putting
2725 the resources into it, right?
2726 Chief {Biasotti.} That is correct.
2727 Ms. {DeGette.} Thank you. And we are going to try to
2728 work to see what the federal partnership that we can have
2729 with all 50 States to help this along.
2730 Thank you, Mr. Chairman.
2731 Mr. {Murphy.} Thank you. And Chief, along those lines,
2732 I understand, for example, California has a law on the books
2733 but only Nevada County, only one county, uses it.
2734 Chief {Biasotti.} In California, it is optional by
2735 county, and only one county, correct.
2736 Mr. {Murphy.} Let me say this. Deep thanks--oh, Dr.
2737 Burgess wants a brief comment.
2738 Dr. {Burgess.} Just as a brief follow-up. Dr. Evans,
2739 in your testimony you talk about the introduction of peer

2740 specialists. This has come up before in briefings that we
2741 have. This strikes me as likely one of the most cost-
2742 effective ways to get rational treatment decisions and to
2743 keep people in their treatment. So I do hope you will share
2744 with the committee your experience with that. We are
2745 constrained under budgetary rules. We can never score a
2746 savings from something that will actually save money. It
2747 always scores as a cost. But perhaps this is one of those
2748 areas where spending the money wisely would in fact be a good
2749 investment. I thank you for bringing that to our committee
2750 today.

2751 Mr. {Evans.} Could I just--

2752 Dr. {Burgess.} Sure.

2753 Mr. {Murphy.} Real quick.

2754 Mr. {Evans.} I think that there are data that support
2755 that peer services are cost-effective. I think it is
2756 probably the most important thing that we have done in our
2757 service that not only gives people hope but one of the real
2758 challenges is keeping people engaged in treatment, and we
2759 have found nothing that is more effective than a person who
2760 has gone through the experience, connecting with another
2761 individual, and keeping that person connected, giving that
2762 person hope, frankly. It makes a huge difference, and we
2763 have one program where we have instituted peers. We have

2764 reduced our crisis visits by a third, and half of those
2765 visits would have resulted in an inpatient stay. So we have
2766 saved millions of dollars, we believe, by implemented peer
2767 services.

2768 Dr. {Burgess.} Thank you. I yield back.

2769 Mr. {Murphy.} Mr. Rahim, you wanted to comment on that?

2770 Mr. {Rahim.} Again, thank you so much for giving
2771 patients voice, and I think a couple of words. I know Mr.
2772 Dart talked about enlightenment, but I think enlightenment
2773 means compassion, dignity and education. So I think each of
2774 us has an ability to be compassionate and we have ability to
2775 treat each patient as an individual and with dignity, and I
2776 think through contact with people who are doing well and then
2777 that follow-up education as a foundation and groundwork, we
2778 can do so much good. So I do thank you again.

2779 Mr. {Murphy.} And again, my thanks to the whole panel.
2780 Just a couple of suggestions. While you are in town, I hope
2781 you stop in at your Member of Congress and say it is
2782 important to do some mental health reforms.

2783 I am committed to do this. It has been since 1963, as
2784 you referenced, Dr. Geller, the last time this country really
2785 did some major mental health reforms. It is long overdue. I
2786 know you are all passionate about this but I hope you
2787 energize your own Members of Congress as well to help them

2788 understand the importance of moving forward on this.

2789 Even though you spoke for 5 minutes and you added a few
2790 minutes to other things, oftentimes people go through life
2791 and wonder if their voice makes a difference, it does. Your
2792 does, and it will continue to echo throughout the House of
2793 Representatives and this Nation. So I thank you a great deal
2794 for all that. And Mr. Rahim, you used the word ``hope.''
2795 Where there is no help, there is no hope, and we will make
2796 sure we continue to work on that help.

2797 So in conclusion, again, thank you to all the witnesses
2798 and members that participated in today's hearing. I remind
2799 members they have 10 business days to submit questions for
2800 the record, and I ask that all witnesses agree to respond
2801 promptly to the questions. Thanks so much. God bless.

2802 [Whereupon, at 12:25 p.m., the subcommittee was
2803 adjourned.]