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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

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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.

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|  
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

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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

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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

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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

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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

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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 \*\*\*\*\*

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|  
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

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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

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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

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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.

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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 \*\*\*\*\*

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|  
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:]

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

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|  
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

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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

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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 \*\*\*\*\*

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|  
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

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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 \*\*\*\*\*

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|

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 \*\*\*\*\*

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|  
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.

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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

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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

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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

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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

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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,

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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

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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:]

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

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|

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.

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|

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?

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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

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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

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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 bed. 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

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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

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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 \*\*\*\*\*

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|

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

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

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|

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.

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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 is 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.

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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.

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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

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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 \*\*\*\*\*

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|

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

735 Chief Biasotti, you can pull that microphone right up

736 next to you, please. Thank you.

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|

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

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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

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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

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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

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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 \*\*\*\*\*

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|

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

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

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|

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

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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.

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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

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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

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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

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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 calls 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

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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 \*\*\*\*\*

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|

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

969 I now recognize Judge Leifman for 5 minutes.

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|

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

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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

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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

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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

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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

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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

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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 \*\*\*\*\*

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|

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.

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|

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

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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

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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

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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

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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 \*\*\*\*\*

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|

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

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

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|

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

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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 lit 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.

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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

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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

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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:]

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

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|

1321           Mr. {Murphy.} Thank you, Mr. Rahim. We appreciate

1322 that.

1323           Dr. Edgerson.

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|

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

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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.

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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

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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.

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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. Edgeron follows:]

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

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|

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

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

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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

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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

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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,

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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

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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 \*\*\*\*\*

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|  
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.

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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.

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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

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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

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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

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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.

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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.

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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

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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 case 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

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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

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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?

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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

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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

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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

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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

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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.

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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

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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

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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. Edgeron. 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. Edgeron, it is estimated that 189,000 people in my  
1913 State with mental illness would be eligible for Medicaid if

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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.

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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.

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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

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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,

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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 decree in 1978. Western  
2017 Massachusetts, the catchment area, is larger than five of the  
2018 States in the United States. At that time western

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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

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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

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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

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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.

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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

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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

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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

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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

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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

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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

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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

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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

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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

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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

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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.

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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

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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

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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

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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

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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

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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

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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

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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

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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

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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. {Elmers.} Dr. Geller, would you like to expand on

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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.

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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. {Elmers.} 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. {Elmers.} 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. {Elmers.} I see. Well, thank you all, and Mr.

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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

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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

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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

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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

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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.

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2691 [The information follows:]

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

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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.

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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.

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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

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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

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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.

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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.]