

**MENTAL HEALTH IN AMERICA:
WHERE ARE WE NOW?**

HEARING
BEFORE THE
COMMITTEE ON FINANCE
UNITED STATES SENATE
ONE HUNDRED FOURTEENTH CONGRESS
SECOND SESSION

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CONTENTS

OPENING STATEMENTS

	Page
Hatch, Hon. Orrin G., a U.S. Senator from Utah, chairman, Committee on Finance	1
Wyden, Hon. Ron, a U.S. Senator from Oregon	3

WITNESSES

Marshall, Brandon, executive chairman and co-founder, Project 375, Chicago, IL	6
Bennington-Davis, Margaret, M.D., chief medical officer, Health Share of Oregon, Tualatin, OR	8
Thomas, Doug, Director, Division of Substance Abuse and Mental Health, State of Utah, Salt Lake City, UT	10
Rosenberg, Linda, MSW, president and CEO, National Council for Behavioral Health, Washington, DC	12

ALPHABETICAL LISTING AND APPENDIX MATERIAL

Bennington-Davis, Margaret, M.D.:	
Testimony	8
Prepared statement	33
Hatch, Hon. Orrin G.:	
Opening statement	1
Prepared statement	39
Marshall, Brandon:	
Testimony	6
Prepared statement	40
Rosenberg, Linda, MSW:	
Testimony	12
Prepared statement	42
Thomas, Doug:	
Testimony	10
Prepared statement	45
Wyden, Hon. Ron:	
Opening statement	3
Prepared statement	46

COMMUNICATIONS

American Academy of PAs (AAPA)	49
American Association for Geriatric Psychiatry (AAGP)	51
Boronow, John, M.D.	52
Burton, Evelyn	53
Clinical Social Work Association (CSWA)	54
Healing Minds NOLA	55
Jones, Nancy	56
Martin, Marilyn	57
Mental Illness Policy Org.	59
National Alliance to End Homelessness	69
National Alliance on Mental Illness (NAMI) and National Association of Psychiatric Health Systems (NAPHS)	70
National Association of Anorexia Nervosa and Associated Disorders (ANAD) ..	72
Nuñez Daw, Christina, MPH, Ph.D.	73
Ranney, Patricia	74
The Trevor Project	74

MENTAL HEALTH IN AMERICA: WHERE ARE WE NOW?

THURSDAY, APRIL 28, 2016

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 2:31 p.m., in room SD-215, Dirksen Senate Office Building, Hon. Orrin G. Hatch (chairman of the committee) presiding.

Present: Senators Crapo, Roberts, Cornyn, Thune, Scott, Wyden, Stabenow, Cantwell, Carper, Cardin, Bennet, and Casey.

Also present: Republican Staff: Kimberly Brandt, Chief Health-care Investigative Counsel; Chris Campbell, Staff Director; and Jill Wright, Detailee. Democratic Staff: Ann Dwyer, Health-care Counsel; Michael Evans, General Counsel; Elizabeth Jurinka, Chief Health Policy Advisor; Joshua Sheinkman, Staff Director; and Beth Vrable, Senior Health-care Counsel.

OPENING STATEMENT OF HON. ORRIN G. HATCH, A U.S. SENATOR FROM UTAH, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The committee will come to order.

I apologize for being late. We had to finish up some Judiciary work, and Senator Grassley asked me to chair that matter. It is a pleasure to see everyone here this afternoon.

Today's hearing will focus on mental health issues in America and the role the Medicaid and Medicare programs play in addressing the needs of those with behavioral and mental health issues. Together, Medicare and Medicaid financed nearly 45 percent of mental health spending in the United States, which amounted to more than \$75 billion—that is with a “b”—in 2014 alone.

As the Senate committee with jurisdiction over these programs, it is our responsibility to better understand the drivers behind the growing needs for and the costs of these services and to work together to develop better solutions for identifying and treating these issues. A report issued by the Medicaid and CHIP Payment and Access Commission in June 2015 indicated that the majority of Federal spending on mental health comes out of Medicaid. That same study found that Medicaid is the single largest payer in the United States for all behavioral health services, including mental health and substance abuse. In fact, Medicaid accounted for 25 percent of nationwide spending on behavioral health in 2009, the year with the most recent data.

One of the many difficulties we face in addressing these issues is that Medicaid enrollees with behavioral health diagnoses have

varied physical and behavioral health needs. Patients often range from young children who need screening, referral, and treatment for autism or depression to chronically homeless adults with numerous diagnoses involving severe mental illness. In 2011, only one in five Medicaid beneficiaries had a behavioral health diagnosis, but they accounted for almost half of total Medicaid expenditures.

Needless to say, these types of behavioral health issues can seriously impair a patient's quality of life, cause disability, and significantly decrease life expectancy. These types of issues are associated with significantly higher rates of chronic disease, substance use disorders, and inpatient hospitalization among Medicare beneficiaries.

In Medicaid, patients with behavioral or mental health diagnoses are more than twice as likely to be hospitalized as those without such diagnoses. The number is drastically higher if the patient also has a substance use disorder. These high hospitalization rates are major drivers in the cost of our Federal health programs. However, what is more unfortunate is that all too often, people with mental or behavioral health issues get no care at all.

According to the 2012 National Survey on Drug Use and Health, nearly 40 percent of adults diagnosed with severe mental illness, such as schizophrenia or bipolar disorder, received no treatment for their illness in the previous year. When you broaden that scope to include all adults with any mental or behavioral illness, 60 percent went untreated for the prior year.

It gets worse. Every year, suicide claims the lives of 38,000 Americans, more than car accidents, prostate cancer, or homicides, and about 90 percent of suicides are related to mental illness, according to the National Institute of Mental Health.

Utah is not immune from this preventable tragedy. Suicide has been the greatest threat to our young people in recent years, and it is time for everyone to take notice. This is absolutely tragic. However, the tragic pattern expands beyond the suicide rate, as overall, people with serious mental illness have an average life expectancy that is 23 years shorter than the nationwide average.

Patients and their advocates say the country's mental health system has been drowning for a long time—not from flood waters, but from neglect. As we talk about solutions, we need to note that the distinction between mental health, mental illness, and severe mental illness is crucial, because each group requires different clinical and policy prescriptions. For example, the current system, proportionately speaking, provides far more support for mental health than severe mental illness. We need to review these priorities and find an equitable solution to ensure that all needs are being met.

Today's panel will give us an opportunity to hear from witnesses who can speak to these issues from almost every perspective. We have an advocate who has suffered with these issues firsthand. We also have experienced professionals who will share their experiences providing care at the local, State, and Federal levels and who can speak to the successes and limitations of providing care in each of those environments.

I look forward to hearing the testimony of today's witnesses and beginning a dialogue with my colleagues on these important issues that hopefully will lead to better solutions. With that, I am going

to turn to our ranking member, Senator Wyden, for his opening statement.

[The prepared statement of Chairman Hatch appears in the appendix.]

**OPENING STATEMENT OF HON. RON WYDEN,
A U.S. SENATOR FROM OREGON**

Senator WYDEN. Thank you very much, Mr. Chairman, and thank you for scheduling this important hearing.

The Finance Committee is responsible for the programs—Medicare and Medicaid—that spend more on mental health than any others in America. That is why this committee, working in conjunction with other Senate committees—the Health, Education, Labor, and Pensions Committee and the Judiciary Committee—now have to develop a fresh approach for protecting and caring for Americans with mental illness. The focus of that approach should be breaking health care, social service programs, and law enforcement out of their individual silos and bringing them together in a coordinated system that deploys their strengths to help people dealing with mental health issues.

The Wyden family knows a little bit about this subject. My brother struggled with schizophrenia for decades, and he had a lot of his health-care bills covered by Medicaid. In and out of halfway houses, confrontations with law enforcement officers, problems securing funds for services or treatments—it was certainly something that has confronted millions of families and demonstrates the need for a fresh approach to helping those with mental illness. Like so many families across the country, you went to bed at night constantly thinking that your loved one might the next day hurt themselves or somebody else.

Because of the lack of appropriate places to meet the needs of those with these mental health challenges, we so often have patients boarded in emergency rooms or in fights with police, sometimes deadly, winding up in prison, where more than half of all inmates suffer from mental health problems and minorities are vastly overrepresented.

Now, I would be the first to say that mental health is not an issue that falls neatly and precisely under just one Senate committee's jurisdiction. A lot of different members with different areas of expertise are going to have to pull the same end of the rope to make progress on this front.

Now, fortunately, Senator Stabenow is here. She has been a champion on these mental health issues. She is our leader here on the Finance Committee, working to build a bipartisan approach. We so appreciate her leadership. Senator Murray, the Democratic leader on the HELP Committee, is also right at the forefront.

In my view, the biggest challenge on mental health is to focus on three priorities. First, there needs to be a sharp new focus on preventing—preventing—mental illness. Patients need better care earlier on to keep the illnesses from escalating.

Furthermore, there are nearly 2 million low-income, uninsured Americans suffering from mental health or addiction in States that have not expanded their Medicaid programs. Those are 2 million Americans who, without treatment or help, are far more likely to

go homeless, far more likely to be incarcerated, far more likely to face addictions, far more likely to commit suicide. The choice to expand Medicaid and give new hope to those 2 million individuals and their families, in my view, ought to be an easy one to make.

Second, services from health care to social work need to be better coordinated. It does not make much sense to tell a person struggling with an illness that they are on their own managing treatments, figuring out what specialist to see, scheduling appointments, and handling medications.

Even outside the doctor's office, there are a lot of areas where people with mental illness often need help that they are not getting today: paying the bills, making it to appointments, maintaining a home. Taxpayer dollars need to reach deeper into our communities and improve the coordination of mental health services to help those whom today the system largely overlooks.

Third and finally, there needs to be a better link between mental health and law enforcement. In many cases, that is going to mean more training on what to do when responding to a person with mental illness. Too many individuals who should be in proper health-care facilities are winding up in jail cells instead.

In my hometown, Portland, the police bureau has recently put a lot of work into building a team of specially trained officers to handle these challenges safely. And I can tell you, in my hometown, at least in the early going, this is paying off big. In my view, more agencies around the country ought to pick up on some of these Oregon lessons with respect to law enforcement.

Of course, and I will close with this, the big challenge is funding. Each year, mental illnesses cost the United States \$450 billion, only a third of which is actually spent on medical care, with roughly \$75 billion, combined from Medicare and Medicaid, making up the biggest portion of the pie.

Those are huge numbers, and a lot of the overall total goes to emergency room visits and jail time. In my view, if you can begin to shift some of that funding to the three priorities I have mentioned—preventing mental illness, better coordination of services, and linking law enforcement with mental health—you will see many more Americans being in a position to manage their mental illness and living healthier lives. Big challenge.

Once again, as you and I have talked about, Mr. Chairman, with our colleagues, this is going to take bipartisan teamwork, the kind of bipartisan approach that Senator Stabenow is working on. But I think that the members here want to come together. We have been talking about this for a long time, and it is time to move forward and actually put in place these new priorities.

I thank you, Mr. Chairman. I also want to welcome all our witnesses and thank them very much for being here.

[The prepared statement of Senator Wyden appears in the appendix.]

The CHAIRMAN. Thank you, Senator.

I have to say that Senator Stabenow and the Senator from Missouri, Roy Blunt, have met with us this morning on precisely these issues, and we are going to see what we can do.

But before we begin this very serious discussion, I would like to bring to everybody's attention that May 3rd is our distinguished

ranking member's birthday. Now, I personally hate birthdays, because when I was a kid, they never had a birthday party for me, and all the other neighborhood kids—we were so poor, we could not afford one, and I just blow them out of mind. It affects me even to this day, although I am getting over it. [Laughter.]

But we just want to mention that Oregon's soccer team, the Timbers, were national champions in 2015 [handing Senator Wyden a wrapped gift box]. [Applause.]

Senator WYDEN. Mr. Chairman, thank you.

The CHAIRMAN. That is a soccer ball.

Senator WYDEN. I can tell. [Laughter.]

The CHAIRMAN. I know you would not know what it is. He only played basketball. But it is a signed soccer ball from the Timbers on your birthday, and we hope you have many more really great birthdays.

Senator WYDEN. Mr. Chairman, thank you. This is above and beyond, and I look forward to coming to your office and throwing the ball around with you. [Laughter.]

The CHAIRMAN. His wife owns the leading bookstore in the country, so I let him get away with anything. [Laughter.]

Let me take a few minutes here to introduce our witnesses. I am very pleased to introduce our first witness, Mr. Brandon Marshall, an all-pro and six-time Pro Bowl receiver with the New York Jets.

In 2011, Brandon was diagnosed with Borderline Personality Disorder and spent 3 months in intensive treatment after struggling with his mental health for years. Since then, he has become a dedicated advocate for mental health issues. His main platform is an organization called Project 375, which he founded to bring awareness to mental illness and to eradicate the stigma.

Brandon regularly produces PSAs, gives interviews and speeches, and partners with other organizations that are dedicated to improving mental health. The list of organizations that he has worked with includes the National Alliance on Mental Illness, Glenn Close's Bring Change 2 Mind, the Kennedy Forum, the National Council for Behavioral Health, and the Linehan Institute, just to mention a few. In addition to speaking arrangements through those organizations and his own, he has given interviews on his mental illnesses on national networks, including CBS, NBC, MSNBC, ESPN, and Fox.

I think I speak for all of us when I say you are an inspiration, Brandon—an inspiration to everyone with mental illness and to all of us here today. I am just very grateful to have you here, and we look forward to hearing your testimony.

Our second witness will be Dr. Margaret Bennington-Davis, the chief medical officer at Health Share of Oregon, which coordinates physical, dental, and mental health benefits for 240,000 Medicaid-enrolled Oregonians.

Prior to coming to Health Share, Dr. Bennington-Davis served as the chief medical and operating officer at Cascadia Behavioral Healthcare, Oregon's largest mental health and addictions provider. Before that, she served as psychiatry medical director for Salem Hospital, as well as the hospital-wide chief of staff.

Dr. Bennington-Davis also served as faculty for the Sanctuary Institute. She has coauthored a book, published articles and chap-

ters, and has done numerous consultations and presentations regarding organizational change, trauma-informed engaging environments, and leadership.

Dr. Bennington-Davis completed her M.D. and psychiatry residency at Oregon Health Sciences University, where she remains on faculty, and received her master's of medical management degree at Tulane University School of Public Health.

Next, we will hear from Mr. Doug Thomas, the Director of the Division of Substance Abuse and Mental Health for the State of Utah. We are grateful to have Mr. Thomas here. He also serves on the board of directors of the National Association of State Alcohol and Drug Abuse Directors, as well as the Utah Substance Abuse Advisory Council.

Additionally, Mr. Thomas serves as a member of the Utah Commission on Criminal and Juvenile Justice. He has worked in the mental health and substance abuse disorder field for over 20 years as a direct service provider and administrator. Mr. Thomas has worked in both urban and rural settings and previously oversaw county services, implementing evidence-based service delivery models.

Mr. Thomas graduated from Brigham Young University, my own alma mater, with a bachelor of science in psychology, and from the University of Utah with a master's degree in social work.

Finally, we will hear from Ms. Linda Rosenberg, the president and CEO of the National Council for Behavioral Health. The National Council for Behavioral Health represents and serves 10 million adults, children, and families served by the National Council's 2,700-member organization.

Prior to joining the council, Ms. Rosenberg was the Senior Deputy Commissioner of the New York State Office of Mental Health. She has over 30 years of experience in designing and operating hospitals, community and housing programs, and implementing New York's first mental health court.

Ms. Rosenberg serves on an array of boards of directors and is a really valued person in this area and a member of the executive committee of the National Alliance for Suicide Prevention.

I want to thank all of you for coming. I just want to mention that each of your experiences and perspectives is incredibly important on these sensitive issues—or set of issues, I think we should say. We will hear the witness testimonies in the order they were introduced.

So, Mr. Marshall, if you will, we will have you proceed with your opening statement. We look forward to hearing from you.

**STATEMENT OF BRANDON MARSHALL, EXECUTIVE CHAIRMAN
AND CO-FOUNDER, PROJECT 375, CHICAGO, IL**

Mr. MARSHALL. Thank you, Mr. Chairman. Ranking Member Wyden, happy birthday.

Senator WYDEN. Thank you.

Mr. MARSHALL. I am grateful and thankful that you guys invited me out to speak before the U.S. Senate and the Finance Committee.

My name is Brandon Marshall, wide receiver for the New York Jets, and I just finished up my 10th year in the National Football

League. In 2011, I was diagnosed with Borderline Personality Disorder. The best way to describe it is, it is an emotional disorder. Some people do not have the skills and tools to be able to cope and deal with some of the day-to-day stress of just life. So I had to spend 3 months in an outpatient program at McLean Hospital learning those tools. I sat in groups and dialectal behavioral therapy, learning those tools and skills; cognitive behavior therapy, where we studied the frontal lobe and tried to understand how to live a healthy and effective life; also, mentalization therapy, self-assessment.

But it was at McLean Hospital where I found my purpose. A lot of times, athletes think that their purpose is to catch a ball, shoot a basket, run fast, but I think we are here for something better. And it was at McLean Hospital where I learned that my purpose is to help bridge the gap in the mental health community.

At McLean Hospital, I was walking out of self-assessment, and one young lady was self-harming herself. Another young lady tried to commit suicide the night before. Another young lady, the week before, in the 3East program, named Sasha, from Canada, committed suicide.

I walked out of that group very sad, and I walked into a parking lot to go to Reebok's headquarters to work out and I saw 200 cars. I looked at those cars as patients. I asked myself, how many more people out there are suffering or suffering in silence and do not even know it?

It cost me \$150,000 to get the treatment that I needed, and 3 months. Reimbursement, it was so bad that I did not even bother to deal with the insurance. My mother, a recovering alcoholic—and she gave me permission to tell her story—also deals with some things. It cost us \$30,000 a month to get my mom the help that she needs. She is now 4 years sober, an amazing woman.

My sister—the same story. My younger brother, who is facing 30 years in prison, actually goes to court on the 28th, it cost us \$150,000 to send him to Yellowbrick in Evanston, IL.

I say that because I truly believe that where we are at today is where the cancer and HIV community was 20–25 years ago, and it is time for us to galvanize the community, stand together, and make a change.

My wife and I, in 2011, also founded Project Prevent. Project 375 is our foundation project. Prevent is a program where we are trying to put on-site behavioral health-care services in our schools to also be preventative and intervene early, because we think that is the key.

I noticed, when I first got my diagnosis at McLean Hospital, I was 50 percent better. I was able to be in group and be validated by people who understood what I was going through. The other 50 percent came from the work.

The call to action is, we need to develop and support programs that are affordable, accessible, and scalable. We need to reimburse mental ailments the same way we do physical. I also think our call to action should be to adopt technology. There are 320 million Americans, and over 100 million are affected by mental illness. We need technology to be able to stand in the gap to help our profes-

sionals, our doctors, our government to get the people the help they need.

Last, this is the last great stigma in our country, and it is a civil rights issue.

Thank you.

[The prepared statement of Mr. Marshall appears in the appendix.]

The CHAIRMAN. Thank you, Mr. Marshall. That means a lot to us, and we appreciate you taking time to come see us.

Mr. MARSHALL. Thank you.

The CHAIRMAN. Dr. Bennington-Davis?

STATEMENT OF MARGARET BENNINGTON-DAVIS, M.D., CHIEF MEDICAL OFFICER, HEALTH SHARE OF OREGON, TUALATIN, OR

Dr. BENNINGTON-DAVIS. Chairman Hatch, Ranking Member Wyden, honorable members of the committee, thank you for this opportunity to offer testimony on the state of mental health services, particularly those provided in the Medicaid program.

For the record, I am Dr. Maggie Bennington-Davis, an Oregon psychiatrist and chief medical officer of Health Share of Oregon.

Before I begin, I would like to thank you, Mr. Marshall, for your remarks about your own experience. Your presence here today is more important than you know.

I would like to begin by describing Oregon's recent innovations in Medicaid. Health Share is the State's largest Medicaid Coordinated Care Organization, or CCO, serving approximately a quarter of Oregon's Medicaid enrollees as the backbone in a collective impact organization of local health plans, health systems, providers, and community organizations.

CCOs were created through a Medicaid waiver in 2012, with the basic premise being that we would coordinate all Medicaid benefits for our members—physical health, mental health, dental health, addictions, even transportation—using a fixed, global budget.

The model is showing early signs of success both in holding down costs and in improving care. As a mental health provider myself, I can tell you this model of collaboration with other parts of the health-care system and even outside the health-care system that are serving the same individuals is remarkable. For the first time, we are able to work across systems of care and address the problems of having thought and planned and built services in silos. What is more, Oregon is predicted to save the Federal Government \$1.4 billion over the first 5 years of implementation of the CCO model.

Oregon's CCO design has brought new attention to and appreciation of the roles of mental illness and addictions in costs and in poor health outcomes. I think of it as us finally discovering the neck—that there is, indeed, a link between the brain and the body.

People with serious mental illness die, on average, nearly a quarter-century sooner than the general public. That statistic is even worse in Oregon, where people with serious mental illness and addictions die, on average, in their mid-40s. These early deaths are almost always because of chronic physical illnesses that are modifiable with the right supports.

The financial impact is also striking. People with chronic physical conditions and mental health and substance use disorders have triple the cost of people with the same physical health conditions, but without mental illness or substance use.

The CCO model compels us to do a much more thorough job of connecting the brain and the body. Much of mental illness, like physical illnesses, is preventable, and the CCO model encourages us to look upstream toward prevention.

Trauma and chronic stress play an important role in all of our lives, in our society, and certainly in the context of the other social disparities of health and poverty in people who are Medicaid members. When Health Share of Oregon first analyzed the people who use the most services and were the highest-cost members, we asked them to describe what had happened to them throughout their lives. The results caught our attention. Often, these folks were born as a result of unintended pregnancy into unstable housing and chaotic families.

Some had been in and out of the foster child system early in life. Many had been neglected or sexually or physically abused as children. Most did not have the kind of childhoods that helped them to develop the emotional regulation skills to prepare them to be successful in school. Most had various erratic behaviors or depression or suicidal tendencies that led them to require services in specialty mental health, if they could get access, or in jails or hospitals if they could not. That is exactly what the Adverse Childhood Experiences Study, published in 1998 by Drs. Felitti and Anda, showed: that adversity and toxic stress during childhood led to significantly more physical and emotional problems in adulthood.

Knowing that mental illness and substance use disorders, along with other ill effects of childhood trauma, can be prevented, Health Share of Oregon felt we had to move upstream in our efforts to improve health. We are focusing on helping our members avoid unwanted pregnancies; get social, physical, and mental health supports during pregnancy; have basic needs met in order to successfully be able to attach to their new babies; and get the support and guidance they need to be effective parents.

My last example is Health Share's foster child initiative. We know from our own data, which mirror national data, that children in the foster child system have a much higher incidence of asthma, Attention Deficit Disorder, obesity, Post-Traumatic Stress Disorder, even hypertension and schizophrenia. What was news to us, though, was that these differences persist and are even higher in children who are no longer in the foster child system, but were once upon a time. So we at Health Share are developing coordination among mental health, physical health, and dental health providers to describe what are the right supports for these children in these health arenas.

Community mental health services, where I spent much of my career, have traditionally focused on people who have already developed chronic and severe mental illness. By adding emphasis to early childhood supports and the social disparities of health, by partnering with early intervention programs in schools, and by paying attention to the mental health supports within a community, all things CCOs can do, perhaps we can mitigate the tragic

long-term effects of the toxic stress described in the Adverse Childhood Experiences Study.

In closing, thank you for this honor and opportunity to comment on our work in Oregon to bring attention to mental health and its inseparability from physical health and overall health, and to emphasize the importance of raising our children in safe and nurturing communities. CCOs are an early promising model for integrating and coordinating care, drawing attention to the health and economic impacts of mental illness and addictions, and clearly point to the need for mental health to include better awareness of the impact of toxic stress in childhood.

Thank you.

[The prepared statement of Dr. Bennington-Davis appears in the appendix.]

The CHAIRMAN. Thank you.

Mr. Thomas, we will take your testimony.

STATEMENT OF DOUG THOMAS, DIRECTOR, DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH, STATE OF UTAH, SALT LAKE CITY, UT

Mr. THOMAS. Chairman Hatch, Ranking Member Wyden, and members of the committee, my name is Doug Thomas. I am the Director of the Division of Substance Abuse and Mental Health in the State of Utah, and I am honored to be here with you today along with these distinguished guests.

Medicaid saves lives and is the backbone of the public mental health system in Utah and throughout the United States. It provides the infrastructure and economy of scale necessary for States to standardize evidence-based practices to provide high-quality care to individuals with serious mental health needs.

The various Medicaid waivers and alternative benefit plans available to States allow them needed flexibility to customize plans to fit the unique challenges, needs, and resources of each State. Case management, peer support services for individuals and families, psychosocial rehabilitation, and respite services are all great examples of Medicaid reimbursable services that help people stay in their homes and communities despite serious illness and allow people the opportunity to reintegrate in place of being alienated from their families and communities of origin.

In 2009, the Institute of Medicine, IOM, issued a lengthy publication about the prevention and early intervention of mental, emotional, and behavioral disorders. The report highlights that almost one in five young people has such a disorder at any given time and that among adults in the United States, half of all these disorders were first diagnosed by age 14 and three-fourths by age 24.

The first symptoms usually precede a disorder by 2 to 4 years, giving us a window of opportunity. Narrowing the gap between the onset of symptoms and evidence-based intervention is critical, as the research is showing us that this early intervention preserves executive functioning and allows people, especially young people and people suffering from the first episode of illness, to recover more quickly with less life disruption. This allows them to accomplish and maintain important developmental tasks, such as estab-

lishing healthy interpersonal relationships, succeeding in school, and making their way into and succeeding in the workforce.

For people with Medicaid, we are able to intervene early with positive outcomes, showing that people can and do recover from mental illness. Treating a person's mental illness improves physical health outcomes and reduces overall health-care costs as well.

There have been various Medicaid and other health-system studies which show that collaborative physical and mental health care lowers costs and improves health outcomes. Prevention and early intervention can help us get upstream and bend the cost curve.

In Utah, 3 years ago, with a new State legislative appropriation and county matching funds, we began to act on the IOM report with what we call Mental Health Early Intervention. This consists of three programs: school-based behavioral health, Mobile Crisis Outreach Teams for Youth in four of our five most populous counties, and Family Resource Facilitation With Wrap-Around to Fidelity, which is a peer support program.

Over the last 3 years, we have increased services to almost 5,000 additional youth, the majority with Medicaid funding. Office disciplinary referrals are down, literacy scores are up, symptoms of mental illness are being reduced, often to the community norm, and families are receiving the supports they need to keep their children safely at home, in their own school, and enhancing their family's natural support system through peer support.

Utah recently passed limited Medicaid expansion, designed to target people with the lowest income and the greatest need: parents with dependent children already on Medicaid, people who are chronically homeless, people with mental illness and substance use disorders involved in the criminal justice system, and people with mental illness and substance use disorders.

We must have Medicaid work with us to find a way to approve a waiver allowing Utah to extend Medicaid coverage to those people in need. People want to be served in the safest, least restrictive environment, and providers want to provide these types of services.

Sometimes children and adults need care beyond what can be provided appropriately in an outpatient or home-like setting. Allowing Medicaid residential services the ability to bill and be paid for room and board would be a great step in the right direction. Room and board is covered during a more costly inpatient hospital stay, but not covered during a more economical residential stay. This disincentivizes lower-cost, short-term residential services in lieu of more costly inpatient hospital care.

With the Patient Protection and Affordable Care Act, the Mental Health Parity and Addiction Equity Act, and more integrated care being provided, there is a need to modernize the Medicaid Institutes for Mental Disease (IMD) Exclusion.

I applaud the efforts of the Substance Abuse and Mental Health Services Administration, Centers for Medicare and Medicaid Services, and the Department of Health and Human Services to modernize this rule, including the option of State waivers around the IMD exclusion.

It must be done cautiously and systematically to ensure we are not re-institutionalizing people but that we are providing a short-

term crisis intervention meant to help people stabilize and rejoin us in our communities where we all work and play and live.

Thank you for the opportunity to testify before you today.

[The prepared statement of Mr. Thomas appears in the appendix.]

The CHAIRMAN. Thank you for your testimony.

Ms. Rosenberg, we will take yours now.

STATEMENT OF LINDA ROSENBERG, MSW, PRESIDENT AND CEO, NATIONAL COUNCIL FOR BEHAVIORAL HEALTH, WASHINGTON, DC

Ms. ROSENBERG. Thank you, Chairman Hatch, Ranking Member Wyden, and members of the committee. I am honored to be here with my very eloquent colleagues.

There is attention to mental illnesses and addictions everywhere we look, from presidential elections to the *New York Times* feature on the Portland police; from the 600,000 Americans who have taken a mental health first-aid course to last week's CDC data showing a 25-percent increase in suicides in the last 15 years.

But attention is not enough. It is not enough for the more than 28,000 who die from an opioid overdose. It is not enough for the more than 41,000 who committed suicide, and it is certainly not enough for their families.

It is not enough—and not because we do not know what works. It is not enough because of the limited availability of what works.

Respectfully, the question before you is not, where are we now but, where do we need to be? If we are serious about moving from pockets of excellence that you heard about from my colleagues to the widespread availability of effective interventions, we need to stop depending upon grants and then wondering why good practices do not spread.

When we have cancer or heart disease, getting access to chemotherapy or a stent does not depend upon a local clinic having a grant. Why are mental illnesses and addictions different?

The answer to where we need to be is the Excellence in Mental Health Act demonstration, a bipartisan initiative led by Senator Stabenow and Senator Blunt. The Act enables and sustains treatment systems that increase access, deliver evidence-based care, and integrate services.

Discussions of access often focus only on increasing beds. Beds can never be effective in a vacuum. Only community-based services prevent readmissions. At a time of Accountable Care Organizations and medical homes, beds alone are not enough. Neither, for that matter, is crisis care. Standing alone, it just is not enough.

The Excellence Act establishes criteria for Certified Community Behavioral Health Clinics, CCBHCs, that provide mental health and substance use services and primary care screening. CCBHCs deliver 24-hour crisis services, coordinating with law enforcement, criminal justice, and veterans' organizations.

But it is not just access. We need uniformly high-quality services. Unfortunately, the adoption of research-based practice is limited. An example is the successful NIMH RAISE study that improved outcomes for youth experiencing a first psychotic episode.

Most communities will be unable to implement this program. Block grant funds and philanthropic grants will not be enough, and thousands of young adults will be relegated to a life of disability.

CCBHCs can move the needle. They are required to offer evidence-based practices and are paid a rate inclusive of these activities. With outcome tracking and quality bonus payments, clinics will be held accountable for patient progress, a step in our move to value-based purchasing.

A key challenge to delivering science-based services is our shortage of professionals. Clinics all over the country struggle to recruit and retain staff. The fundamental barrier is that most clinics cannot afford skilled staff or investments in technology to extend staff's reach.

Those of you who have ever run a business know this is unsustainable. The Excellence Act offers certified clinics Medicaid payments based on the cost of treatment. They can hire critical staff and leverage new technologies, and even those historically opposed to prospective payments, like the National Association of Medicaid Directors, acknowledge there is not a better solution.

The average age of death, as we have heard, for Americans with serious mental illness is 53. The culprits are heart disease, lung disease, and cancer. And people with chronic physical illnesses, as you have heard, often have co-morbid depression and anxiety.

CCBHCs represent a foundational opportunity to advance the way care is integrated and coordinated. Shining a spotlight into the shadows of mental illnesses and addictions is not enough. The Excellence in Mental Health Act is where behavioral health needs to be.

Twenty-four States are now planning their participation in the demonstration, yet the law sets an 8-State limit. Every State that wishes to create and sustain quality systems should be able to do so. We urge you to allow all 24 States to participate and to open the planning process to the remaining 26 States. CCBHCs will transform services in this country, and that is what I call reform.

Thank you.

[The prepared statement of Ms. Rosenberg appears in the appendix.]

The CHAIRMAN. Thanks to all of you. This has been compelling testimony. I am very grateful to you.

Mr. Marshall, the stigma around mental health is very, very important. I want to thank you for sharing your personal story and perspective on living with Borderline Personality Disorder, and I want to also thank you for your courage in taking a leadership role to end the stigma surrounding mental illness.

You have spoken at length about the importance of proper treatment for all people, regardless of whether they are a parent in the suburbs of Salt Lake City, a single adult trying to make ends meet, or a wide receiver in the NFL who is admired by millions.

Can you expand on your work through your organization, Project 375, to end the stigma around mental health?

Mr. MARSHALL. Yes. First, like I said in my testimony, where we are at today is where the cancer and HIV community was 20–25 years ago. One of the first things they did was, they galvanized the community. They came together, they changed the narrative in the

media, they broke down the stigma. Back in the day, it was called the Big C. So that is where we find ourselves.

So we spend a lot of our time telling stories, similar to what Glenn Close does. I think it is important for influencers in our country to stand up and say, "This is who I am, and this is what I have been dealing with." It could be them or it could be a loved one.

So that is number one: breaking down the stigma. And I think it is important, because there are a lot of people out there suffering—and suffering in silence. Some people do not even know that they are suffering. That is their norm.

The second thing, which I always call the tangible, is preventative and intervention work. We want to put onsite behavioral health-care services into every single school. But to be honest with you, I am now realizing that that is really hard to do. So that is why I mentioned one of the calls to action is adopting technology to not replace, but help our professionals, our government, our doctors, stand in the gap. And so we are fighting hard for that, and we are looking for your support in any way we can get it.

The CHAIRMAN. Thank you. I am very proud of you for being willing to stand up on these issues.

I want to thank each of you witnesses for your work in this very important area. To the extent that each of you is involved in developing policies to address mental illness, what factors do you consider for changes to the mental health delivery system? If you would, I would like you to highlight any successes you have seen in mental health delivery as well.

We can start with you again, Mr. Marshall, and go from there.

Mr. MARSHALL. I will pass it to you, Doctor.

The CHAIRMAN. That would be fine. Let us start with you.

Dr. BENNINGTON-DAVIS. Thank you, Mr. Chairman.

I would like to mention a very particular initiative that Health Share of Oregon is partnering in with several delivery system parts in Portland, called Project Nurture.

Project Nurture is a program that is specific for women in Medicaid who are pregnant and who are addicted. This program encourages women to seek prenatal care as early as possible. We have a partnership with the Department of Human Services to make sure that there is an understanding that we are, in fact, giving the woman the support she needs to successfully get through the pregnancy. And during the prenatal period, the woman is also getting addictions treatment, she is getting peer support, and she is getting therapy, and her baby is also being taken good care of.

The program has staff who stay with the woman throughout the delivery period and then even postpartum to help her attach to her baby and learn the right parenting skills to give that baby a good start, all the while getting addiction treatment.

It is that kind of coordination and collaboration across mental health and physical health and that kind of multidisciplinary approach that I think is going to change outcomes, reduce mental illness, reduce addictions, and give people a better start, and we can do that because of our Coordinated Care Organization structure.

The CHAIRMAN. Thank you.

Mr. Thomas, let me just ask you this. The mental health workforce is an issue about which I care deeply. You have dedicated a great deal of your career to increasing peer support services in the State of Utah. Could you please share the impact of that model and ways in which it has spread to different States to make meaningful local impacts?

Mr. THOMAS. Having peer support is important, paraprofessionals—they are people who have lived experience, who have had a mental illness or a substance use disorder and are in recovery—and/or family members who can go in and do the same thing for families who are struggling with a child, who have been through the child welfare system or the juvenile justice system.

And they go in and they—just like Mr. Marshall—bring a lot of credibility with them. They are someone who has been through the system and has recovered and flourished. And so what they do is, they help other peers and are able to link them to services. But also, I think the main ingredient is, they give them hope. They give them hope and a vision of a better future, and many times, people really struggle to maintain that hope.

So we have done that in Utah and had great success. We now have family resource facilitators in some of our juvenile courts, in child welfare with the 4(e) waiver that is happening in Utah, which we appreciate your work on in that regard as well, to provide more home and community-based services in lieu of residential and inpatient. It means a lot and makes a big difference in people's lives.

The CHAIRMAN. Thank you.

My time is up. Senator Wyden?

Senator WYDEN. Thank you very much, Mr. Chairman.

Just for you, Mr. Marshall, your work to deal with the stigma associated with mental health is appreciated. I have been really struck by how negative perceptions about serious mental illnesses are actually growing and that one in three people say that they would not want their kid to be friends with another child who is diagnosed with depression. So a big, big thanks. I think that is enormously valuable work that you are doing to highlight the stigma issue.

My first question will be for you, Dr. Bennington-Davis. We are so proud of the work that you all are doing at home.

I want to focus on a group that is really getting left out in this debate, and that is kids. Children suffering from mental illness often are sort of given short shrift here, and research shows that half of all lifetime cases of mental illness begin by age 14.

So it would seem to me that screening and treating mental health disorders is especially critical for children. Again, this just seems to be an area that is being missed, and it is not some partisan thing, it is just being missed.

If you could make one recommendation with respect to children with mental illness, what would it be? I think my first choice, again, is that prevention issue that Mr. Marshall has highlighted and I have been interested in, which is screening and treatment.

What do you think would be your top priority in terms of trying to get kids help early?

Dr. BENNINGTON-DAVIS. You stole my answer, Ranking Member Wyden. One of the pushes that we have in the Coordinated Care

Organization setup in Oregon is to meet certain incentive metrics—so outcomes that are incentivized by the program—and one of those incentive metrics is to ensure that children get developmental screenings at the correct times.

Another one in the foster child system is to coordinate physical health and mental health—and dental, for that matter—screening as soon as the child enters DHS custody.

I think things like that that actually structure, require, and then incentivize and reward the provider system for doing the right things at the right times, are going to make a big difference in the lives of our kids as they go through the system.

Senator WYDEN. Let me bring our other panel members into the next question.

We are obviously not the Judiciary Committee, and that is why I indicated that several committees are going to have to be involved here. But there are several pieces to this issue. There is prevention, better coordinating the services, and obviously—again, in Oregon, we have tried to highlight the relationship between law enforcement and mental health services, and it is surely about time.

Of people who were shot and killed by police officers in 2015, 25 percent displayed signs of mental illness, and more than half of all prison and jail inmates have a mental health problem. So in Oregon, we sought to try to break some new ground here in terms of trying to define different relationships between law enforcement and mental health.

I would be curious—maybe we will work our way the other way. We can start with you, if we might, Ms. Rosenberg.

What would be your top priority in building a new, better coordinated relationship between mental health practitioners on the health side and law enforcement?

Ms. ROSENBERG. I think one of the biggest problems you will hear from law enforcement is, what do they do with someone who clearly has a mental illness? I hear that over and over again.

When you read my bio, you talked about my being involved actually in the first mental health court in New York City. I think they get someone clearly having a problem, maybe picked up on the street, maybe the family calls, there is nowhere to go, and I think that is one of the reasons we are so interested in fundamental change and ensuring that everybody knows where to go.

Those services are available 24/7. People who are professionally trained can intervene and the police are not left alone, and that is before anyone gets either booked or arraigned.

Senator WYDEN. Mr. Thomas, do you want to take a crack at that?

Mr. THOMAS. Sure. Crisis intervention training for police officers, mental health, first aid for first responders, are great models on the law enforcement side. And we have had a great justice reinvestment initiative in Utah with help from the Pew Foundation, building it based on risk, needs, and responsivity and having it very clear what the criminogenic risks are and then what the substance use and mental health needs are, and then targeting programs that help people who are low criminogenic risk, who have high mental health or high substance use disorder needs, and get-

ting them into treatment programs that work and that keep them from the recidivism cycle.

Senator WYDEN. I am going to have to be on the floor in a few minutes, but I want to thank all of you. You have just been a superb panel.

Senator Stabenow, who, of course, has championed this cause for us here, will serve as our ranking minority member.

Mr. Chairman, I very much look forward to working with you and our colleagues.

The CHAIRMAN. Thank you so much.

Senator Roberts, you are next.

Senator ROBERTS. Well, thank you. Before Senator Wyden leaves, a special happy birthday to you, sir.

Senator WYDEN. Thank you.

Senator ROBERTS. We have worked together for quite a few years. I used to give you every extra 5 minutes that you needed on the Intelligence Committee.

Senator WYDEN. Always. [Laughter.] And we are Kansans.

Senator ROBERTS. Yes, we are both Kansans. I had the feeling that if you took that soccer ball and kicked it over to Ms. Rosenberg, Brandon would leap across there and catch it—

Ms. ROSENBERG. You have no faith in me—

Senator ROBERTS [continuing]. Laying out. [Laughter.]

The CHAIRMAN. Could I interrupt you for just a second? I have to leave for a few minutes. So the next one will be Senator Stabenow and then Senator Cornyn. So if you will follow up yourselves, I have to go speak to a group, and I will be right back.

Senator ROBERTS. So you are not leaving me in charge, is that right?

It is a coup. All right.

Mr. Chairman and Senator Wyden, thank you for holding this hearing. It is our committee's commitment to reviewing and finding ways to improve our mental health system.

Mr. Marshall, I did not know when we were having a good discussion back in the back room here that you held the record for most receptions, 21, in an NFL game. I thought that was Art Monk of the Redskins. [Laughter.]

One of five players in NFL history to have at least 100 receptions in three seasons—I thought that was probably Lynn Swann of Pittsburgh, whom you are familiar with. The NFL record for most receiving touchdowns in a single Pro Bowl game, I thought that was Jerry Rice. But that is you.

Mr. MARSHALL. Yes, sir.

Senator ROBERTS. And it is you who is sitting there who has really provided a beacon of hope for an awful lot of people. That is really special. That is even more special than going over the middle and getting popped by a linebacker and still holding onto the ball.

I really appreciate your testimony, and on the back page, if I can find it, you say, "As an NFL wide receiver, I have caught hundreds of passes during my career. Today, I am throwing one to you." "You" is us.

I still have good hands. I will not fumble it. [Laughter.]

I have a little bit different kind of questioning here. Last month, the Center for Medicare and Medicaid Innovation, CMMI—it is a brand new outfit, and we already have a brand new acronym—they proposed sweeping changes to how we pay for prescription drugs under Medicare Part B. This is under the heading, “we need to do good things on behalf of mental health, but we have to also prevent bad things from happening,” and I am concerned about this center.

I know many of my colleagues on this committee share my concerns with how this demonstration, quote, “could affect patients’ quality of and access to care.”

As the president of the Kansas Medical Society described to me in a letter just yesterday, this demonstration, quote, “will force Kansas Medicare beneficiaries with serious, sometimes life-threatening conditions to participate in a CMS innovation initiative, disrupt their treatment processes, and impede their access to needed medications, with no evidence of improved health outcomes or financial gains for the Medicare system.”

Most concerning for the purpose of our hearing today is the proposal’s impact on those suffering from severe mental illness: schizophrenia, schizoaffective disorder, or bipolar disorder with psychosis. It is often extremely difficult for patients with these conditions to adhere to oral medications, and, as a result, many rely on long-acting injectable antipsychotics, which would fall under Medicare Part B.

Phase one of the demonstration would reduce reimbursements for all new second-generation long-acting injectables. Let me repeat that: it would reduce reimbursements. In phase two, CMS could decide—probably would decide—some of these medications are now deemed, quote, “high-value” and limit access to them.

This could result in the patient going to a hospital, which could be a lot further away, especially in rural Kansas, Texas, or Michigan, where we may end up paying more for the same treatment, or these patients could be switched to products that are less effective or have more side effects, which is where I get particularly concerned about the government coming between you and your doctor. This is particularly concerning for a patient with schizophrenia, as switching treatments impacts the likelihood of relapse, increasing the debilitating and lasting adverse effects on a progressive condition.

So my question to all of you on the panel would be this. Have you heard about this proposed demonstration, number one? Do you share these concerns about access to appropriate medications for those with mental illness?

We will start with you, Doctor. Pardon me—Ms. Rosenberg.

Ms. ROSENBERG. Yes. Thank you for promoting me. It feels very nice.

Senator ROBERTS. I just bestowed that upon you.

Ms. ROSENBERG. But I do feel strongly about this, particularly about reducing the price or the payment for injectables. As a country, we use less injectables than any other place in the world.

It is a highly effective treatment. Patients and their families are interested in it, and it is harder to administer than giving someone a script.

So the minute you make reimbursement lower, you are going to lower utilization even further. That is a very big mistake.

Senator ROBERTS. Mr. Thomas?

Mr. THOMAS. Before I became the State Director, I was the lead on a team that worked with people who struggled with schizophrenia and bipolar disorder—in and out of the hospital and State hospital for many years—and we did a lot of outreach to them in their homes and watched them take their medication to help them, because often that was one of their major things that led to their hospitalizations.

When the long-acting injectables, the new generation, came along with much less side effects than the old injectables, it was a godsend for a lot of people. They were able to get their shot and then not worry about it for a month and not have the daily reminder or the daily struggle to take the medication.

For me, this is deeply personal, and I think anything that gets in the way of that is dangerous for people.

Senator ROBERTS. Dr. Bennington-Davis?

Dr. BENNINGTON-DAVIS. Senator Roberts, Health Share, the company I work for, does not deal with Medicare, and I was unaware of the proposal. So I have learned from you today. Thank you.

Senator ROBERTS. Brandon Marshall?

Mr. MARSHALL. Yes. This is my first time hearing it, but I will say that I agree with Ms. Rosenberg and Mr. Thomas.

I speak a lot from experience. My first charity event after relaunch, after I spoke and said that I was diagnosed with borderline personality disorder and I spent 3 months at McLean Hospital, we had a charity event soon after, and there was a young lady and her family who came in, and we stayed in contact over the years.

Last year, she introduced me to injectables, and her experience is night and day. She was someone who was heavily sedated with medication, and this past year, she has just been amazing.

Senator ROBERTS. I appreciate that. I apologize to my colleagues for going way over my time. Let me just point out that over 300 organizations are asking that this rule be withdrawn. I agree.

This is another case of rationing health care. There are four rationers. This is one. My fears are coming home to roost, because we have a proposal which, if implemented by CMS, could ration health care.

That is where we fumble the ball, Brandon.

I recognize the distinguished Senator, my colleague and friend, Senator Stabenow.

Senator STABENOW. Thank you very much. Thank you, Senator Roberts. I share your concern about this issue and have written a letter, as well, expressing concern about this policy.

Welcome to all of you. It is terrific to have each of you here and share your experiences, and thank you for what you are doing.

I do want to make note that the last Finance Committee hearing on mental health was in 1999. So we are overdue.

I think it is also important to stress that President Kennedy signed the last law he ever signed on October 31, 1963, when he signed the Community Mental Health Act, and we have yet to fully implement the vision of the law that was enacted in 1963.

For me personally, in 1963, I was the eldest child in a family where my dad was suffering with mental illness. All of us have in one way or another been affected by mental illness.

Mr. Marshall, I can tell you that I am so grateful that you are here. I understand what it is like with the stigma for a family in a small rural town in northern Michigan, where folks do not understand, even though my mom was a nurse and it was a medical family, trying to understand what was happening with my dad: misdiagnoses, lack of services.

I also know what happens when you get the right diagnosis. At the time, my dad was diagnosed as a lot of things, but finally, accurately, manic depressive, which we now call bipolar, which is a chemical imbalance in the brain. He finally got the services he needed, the medication he needed, and lived the rest of his life healthy and productive.

So that is what fuels my commitment to this, both from a family as well as from a professional standpoint.

We also know that one out of five adults has mental illness—I hear one out of five, I hear one out of four; we are all affected by this—and 60 percent of them do not get the treatment they need in a year now, today. So you fast-forward from what happened to my father.

It is also, I think, interesting to note that the Cook County jail and the Cook County sheriff has hired a psychiatrist to be the head of the jail, and he said, “This is not surprising, because over a third of the people I house have mental illnesses.”

So we know the impacts of this, whether it is a hospital emergency room, whether it is the jail. What we need is people to get the services that you have described today, and get them when they need them, get them early and be able to go on and have productive lives.

So I have worn a lot of different hats on this one, chairing at the State level in Michigan the mental health committee, and I have seen what works and what does not work. I have lived what works and does not work.

I am very excited about the fact that we have a moment now where we have wonderful bipartisan interest in behavioral health, mental health, and substance abuse. They are all connected. We have wonderful work going on in a bipartisan way, and it is time to seize this to be able to structurally change what we do so that, as Ms. Rosenberg has said, we are not depending on grants that come and go.

We do not depend on that if you have heart disease or kidney disease or you have a broken back. We do not go, well, you know, the grant ran out this year, so you will have to wait.

But yet, if it is a disease above the neck, if it is a disease in your brain, we have a very different system. And that is the challenge, I think: to integrate our health-care system so that brain diseases do not rely on grants when every other kind of disease relies on a health-care system with full reimbursement. That is why I am so grateful to all of you. I am always saying that health care above the neck needs to be the same as health care below the neck.

Before asking a question, I do want to just say that we have begun that process. The exciting thing is, 2 years ago, on the last

SGR patch that we did, we passed something that Senator Blunt and I worked on for some time to set up a requirement for quality behavioral health standards, 24-hour psychiatric emergency care, integrated care with primary care, help for families, all the things—substance abuse, mental health.

So we have these standards now and know what it looks like. We need to fund it, and we were able to get funding for eight States to be able to meet that, and 24 States stepped up. Now we are saying we need to provide the opportunity for every State that meets quality standards to be able to receive the funding and get the reimbursement, and I am very grateful for Senator Blunt's working with me so closely on this for so long now.

So I want to start with Dr. Bennington-Davis. I know Oregon is one of the States that has received a planning grant, one of the 24 States. Could you talk a little bit about why you applied for the planning grant and what you would hope for if you were able to fully provide services, quality services, and get reimbursed for it? What would that mean?

Dr. BENNINGTON-DAVIS. Thank you, Senator Stabenow. I just have to remark that I think your legislation is the most important legislation to emerge regarding mental health since President Kennedy signed that act. So thank you very much for your efforts along those lines, and I am really excited about it.

For 10 years, I worked for a community mental health provider agency, and we served about 15,000 people a year, most with serious and persistent mental illness, and the one thing that was missing was, as you said, the below-the-neck part. Even though so many of the people that we served had very serious chronic physical conditions, they either could not or would not get access around their primary care needs.

In the agency where I was, we were not set up to provide those services. So the CCBHC gives us an opportunity to really up our game and to connect the brain and the body and to understand the person as a whole person.

Ever since becoming an M.D., I have understood that that is the big gap. You cannot be a psychiatrist without thinking about the whole person, and certainly you cannot be a person in community mental health services without worrying about the rest of your health. They just impact each other so constantly.

So it was a no-brainer to apply for the CCBHC grant. I am thrilled that Oregon got it. It fits very nicely into the context of all of the other innovative things we are interested in in terms of integration. We need to integrate both ways, though, not just behavioral health into primary care; we have to integrate primary care into community behavioral health services.

Thank you again.

Senator STABENOW. Thank you.

I would just ask one quick question of Ms. Rosenberg. There are lots of things that I would love to ask all of you, but you touched on helping veterans. And one of the things we worked on as we looked at integrated care is integrating with veterans who may not live near a VA facility but maybe someplace in the community around their State.

We know that 22 veterans commit suicide every day. We know all the numbers. More than 25 percent of veterans have a psychiatric diagnosis.

How does providing fundamental reimbursement for community care make a difference for veterans?

Ms. ROSENBERG. It is going to make a tremendous difference for veterans and for their families. You know, one of the things we sometimes forget is, when someone comes home from service and comes home with a disability—traumatic brain injury, PTSD—it affects not only their spouse, but their children.

So we are going to create opportunities for treatment in every community, with your leadership, and we thank you so very much. It will make a tremendous difference.

Once someone is no longer involved in the VA, now is working with their families, those problems do not go away, and now they will have community capacity, and people will know where to go.

I think that is the other issue. Brandon Marshall—and, of course, I am a hero now to my grandson because I am sitting at this table with him—in addition to that, has brought attention to this. Now for people who are telling their story, it is, “Where do I go?”

The calls I get personally are from family members and from friends across the country who have someone with a mental illness, a child, an adult, and they really do not know where to go.

We have to create that vision you described from 1963, that there is a place in your community you can go and that, if your primary care physician who has someone on their staff who is a behavioral health specialist, if they feel you need more than they can provide, they have someplace to send you.

So I think we want to be a community resource. We know what to do. It is not that we do not. The grants have been very successful. They have proven it. Now, it is about how we systematize it so that every community has the resources they need, including the substance use resources.

Let me also say that both Mr. Thomas and Dr. Bennington-Davis worked in the past at member organizations of the National Council. It is no surprise they are in the positions they are in now. They were stars then.

Senator STABENOW. Thank you very much.

I think I am turning to Senator Cornyn.

Senator CORNYN. Thanks to each of you for being here today, and I appreciate your contribution to the discussion.

Actually, there has been a discussion going on for a while now, and I applaud Senator Stabenow and Senator Blunt, whom I know work very closely together bringing mental health services to the community, Federally Qualified Health Centers, which I have always been a supporter of. But recognizing that these are existing health-care facilities, if we are able to enhance access to mental health services at those existing facilities, that is a pretty efficient and pretty effective way of dealing with this issue.

I come at this from a law enforcement perspective, as a recovering judge and Attorney General, but principally what I have been struck by is the successes at local levels in dealing with things like—Senator Wyden talked about training for law enforcement to

deescalate confrontations between police and a person who is suffering a mental health crisis, but that takes training to know how to deal with it.

Also, our jails often become the mental health provider of first resort, or maybe it is of last resort. I actually met the other day through a friend of mine—the sheriff of Barrett County, San Antonio, TX—someone she introduced to me as the largest mental health provider in America. Meet the sheriff of the Los Angeles County jail.

So that speaks volumes for what our law enforcement community needs to do in order to become better-informed and better-trained. And I think there are some great models at the local level, and we need to identify those best practices and then scale those up and make those available across the country.

Here is an interesting statistic, or it was to me. The Federal Government provides \$2 billion a year, \$2 billion a year, in assistance to State and local law enforcement, but less than 1 percent of that is directed toward mental health issues. To me, that just seems like it cannot possibly be right. Since the Federal Government does not have limitless access to resources and we are going to have to find ways to pay and live within our means, it just seems to me that if we are already spending \$2 billion a year, that maybe, just maybe, we ought to look at the allocation of some of those funds and direct them toward training and other things that the Federal Government can do in terms of highlighting best practices that already exist across the country.

The other thing is, I was struck by Pete Earley's book, "Crazy," and had the honor of meeting Pete. Pete has been courageous to talk about his family's experience, Mr. Marshall. He had a son who had a mental illness, but the biggest problem he had, his family had, is his son simply would not cooperate with his health-care treatment, would not take his medication, for example, and ended up in jail.

As we have seen, that is where many people end up, either that or homeless, living on the street. One of the biggest problems, it seems to me, is not about reimbursement, it is not about access to the best drugs necessarily, but it is, how does a family member get the cooperation of a loved one who happens to be mentally ill?

I think about somebody like Adam Lanza's mother in Connecticut, the shooter at Sandy Hook. His mother knew he was mentally ill and he kept getting sicker and sicker and sicker, and she did not know what to do. She could have had him involuntarily committed, but that is not forever. That is just for a short-order treatment. You can imagine the tension and friction in their relationship if she were to get an order for him for involuntary commitment.

So there are a lot of really interesting things that are happening, as I have said, across the country, including things like assisted outpatient treatment, which does not require an involuntary commitment, but it is a civil court order requiring people to comply with their doctor's orders.

Right now, the courts have the authority of probation, or parole even, and the control that comes along with that, but unless you have those tools, unless you are a drug court or some other judicial

office, you do not really have the resources to require people to comply with their doctor's orders and take their meds.

My understanding is that a lot of what we see happening resulting in people ending up in jail, living on the street, or crowding our emergency rooms—if we could just do a little bit better in terms of getting people not only access, but ensuring better compliance with their doctor's orders, they could do a lot.

We have an effort that I know of. In addition to what Senator Stabenow and Senator Blunt have been doing, Senator Alexander and Senator Murray in the HELP Committee—Health, Education, Labor, and Pensions Committee—have a bill. Dr. Bill Cassidy I know is working with the Senate version of the House bill, along with Chris Murphy, on the larger mental health package that Tim Murphy has been proselytizing on quite a bit. I have a bill called the Mental Health and Safe Communities Act bill, which is from the Judiciary Committee jurisdiction.

So to the ranking member's point, we have all these different committees, and because of the silos we create here in terms of how we look at things, I think what we need is a better-coordinated effort, even internally within the Senate, to try to come up with a consensus package that we can actually act on, because I think there is a lot we can do in this area.

Mr. Marshall, I think you are right. This seems to be kind of a magic moment when people finally realize this is pretty important and we need to act on it.

So thanks, all of you, for being here. We look forward to continuing to work with you, and we ask for your continued advice and support.

Thank you.

Senator STABENOW. Senator Casey?

Senator CASEY. Thank you very much. I want to thank the chairman and ranking member for calling the hearing, and I also want to commend you, Senator Stabenow, for your work on this legislation over time.

I want to thank the panel. This is a panel that brings a lot of personal and professional expertise to this, and I am grateful to Brandon for being here. He has roots in Pittsburgh and I wanted to note that for the record.

Folks in New York and around the country know Brandon well, but he does have roots in Pittsburgh. I want to make sure—you grew up in East Liberty?

Mr. MARSHALL. East Liberty, yes.

Senator CASEY. Sometimes they pronounce it as one word in Pittsburgh.

Mr. MARSHALL. Correct.

Senator CASEY. But we are so grateful. I wanted to thank Brandon Marshall for his testimony, and I will excerpt just a few lines from his written testimony, talking about accepting mental illness as a disease, saying, number one, that it needs better research, better screening, better funding. You also say that we need to have better recognition of new therapeutic treatments proven to work. I guess if I were making a list, I would say number five would be education in schools.

So you have given us an assignment—to use your words: throwing us a pass. So we have an obligation to catch it and do our best to run with it. So I want to thank you for that.

I want to start with, and I may only have time for one broader question, but, Dr. Bennington-Davis, so much research, which is part of your testimony, shows the connection between childhood poverty and outcomes as adults. One of the ways to thwart that or prevent it from happening is early intervention.

I guess one kind of broad question—and you may have addressed this more broadly in your written testimony. But we know that early intervention works. I guess it is a corollary to “good treatment works,” and we are having a lot of discussion on the opioid crisis. But we know that in this context, early intervention works.

What can you tell us about, in your professional opinion, the best method of early intervention? Is there one strategy that works, or two, or is it more than that?

Dr. BENNINGTON-DAVIS. Well, thank you for the question, Senator Casey. I think it has to be a complex answer because it is a complex set of issues, and poverty is complex, and the stresses that go along with poverty are complex, and the social disparities of health that are part and parcel of people’s lives are extremely complex. But if I were to try to boil down what I think scientifically we are aiming at, I think what we are aiming at is to decrease the overall toxic stress that a young brain is experiencing both before birth and after birth.

If we can figure out how to decrease the overall stress, the adversity, if a child can be in a safe and nurturing relationship with a caretaker, in a safe and nurturing home, and in interactions that help that child’s brain develop robustly, then I think humans are incredibly resilient and can overcome most things.

So I would aim at that, and there are a lot of ways to do that. There are parent supports, there are community supports, there certainly are programs in schools and so forth, but that would be the thought in my head as I set about trying to think of an array of programs.

Senator CASEY. I guess not to put too fine a point on it, the earlier we do early intervention, the better.

Dr. BENNINGTON-DAVIS. Yes. I think James Heckman, the Nobel Prize economist, says the earlier you intervene, the way more pay-off that there is, and I think we in health care have to grasp that concept as well.

Senator CASEY. I may just have one more question.

Ms. Rosenberg—I could call you all doctors; you have a lot of experience. Psychological services in our State are not covered by Medicaid, and that is, obviously, a hurdle we have to overcome. What is the best way to expand that kind of access, access to mental health services generally?

Ms. ROSENBERG. CCBHCs are excellent. Actually, your State is a grantee. It just so happens that the chairman of our board is from Pennsylvania. Her name is Susan Blue. We have members all over your State, a very active association, and I think they are very committed to it.

I think what we need is a standard that does not exist now in terms of competence. That includes psychological treatment. I

think right now what has happened is, for most community-based behavioral health organizations, they cannot afford skilled staff, believe it or not. So you have a physician who can do many things sitting and writing scripts all day. You have peers who do many important things. But in between, you really lack staff that can deliver cognitive behavioral therapies that are very effective for both depression as well as for more serious severe depression and other illnesses.

So I think we have to raise the floor, and this is your opportunity. And that is why we are so grateful that you have so many committees interested in this, and that is why, if there was one thing I could ask based upon my years of experience, it would be: do something that is systematic.

We do not necessarily need more grant programs. We know they work. There are great things going on out there. You heard it from the panelists. Now, it is about taking it to scale.

Senator CASEY. Great. Thank you very much.

The CHAIRMAN. Thank you.

Senator Thune?

Senator THUNE. Thank you, Mr. Chairman. And thank you to the panel for all your great insights today.

I just want to ask, Mr. Thomas, according to the Utah Department of Human Services' website, suicide was the leading cause of preventable death in Utah in fiscal year 2014. As you may know, South Dakota has experienced high rates of suicide, particularly among young people, and particularly on our reservations and in our tribal communities.

So my question is, what strategies has your department employed in order to reduce the high suicide rate in your State, and what are some of the other traits that you have noticed in successful suicide prevention programs? And maybe, if you could, talk a little bit about tele-health as an early intervention technique that might help or if it has been used in your success out there.

Mr. THOMAS. Thank you, Senator Thune.

We have a State Coalition for Suicide Prevention, and what we have done is, we have taken that State coalition and we have built up some of the substance use disorder prevention coalitions and had them add in suicide prevention as one of the things that they are addressing at the local level.

So we have over 40 coalitions that are attacking this problem at the local level throughout our State. We have had people from Zero Suicide, which is a national effort to lower the suicide rate and to have us look at comprehensive care; we have had experts come in. We have done surveys and studies with our workforce to find out gaps in their knowledge.

We have brought in training for them. Many people even in our field do not have the training that they need to address suicide specifically. So we have brought in evidence-based training to our State to target suicide-specific actions, behaviors, thoughts.

Another thing that we have done is, we have worked with all of our health-care providers, our health-care system, as well as our local mental health and substance abuse authorities, to have a standardized language and a standardized screening and risk assessment process.

So we are using the Columbia Suicide Severity Rating Scale. IHC, Intermountain Healthcare, our largest provider, has already implemented that into their health-care record, their electronic health record, as well as in their emergency room, crisis, and out-patient settings.

Then our local authorities—they are also the county providers—are implementing that. So everyone will be talking about risk the same way. Our crisis lines, they are doing the same training, and then we are also using the same safety plan, the Stanley Brown safety plan, which is top-of-the-line and really gets at five different factors to try to keep people safe. We have done a lot of campaigns and had a lot of legislators, local legislators, who have helped us pass some bills to target this issue as well, and we feel like we are making progress.

As you have said, we have had a really high suicide rate, along with the other intermountain States, and for the first year, a year ago, our data showed that we have actually dropped that rate a little bit. One person dying from suicide is too many, which is why we are part of the Zero Suicide initiative, and I feel strongly and passionately about this issue.

Tele-health for rural Utah—we have two counties that are over 7,000 square miles. One has 15,000 people, another has 60,000 people in it. Tele-health is definitely part of the solution, part of the answer, but we need to develop local resources as well, and have local trained staff to be able to help families and communities.

It does not always have to be professionals, but we do need professionals involved in the care, and tele-health has been used in our State to try to address this. It is not to scale. It needs more infrastructure, but it is definitely something that is part of the solution.

I believe it is good in South Dakota, and your Health and Human Services has been a great partner in this. We have had a Region 8 meeting with all of the States in our region to discuss suicide prevention because of the high rates in our region.

Senator THUNE. Thank you.

Mr. MARSHALL. Can I add to that?

Senator THUNE. Yes. Yes, please.

Mr. MARSHALL. I think Ms. Rosenberg was right when she said it needs to be systematic. Sometimes we do too much. As a patient and going through it and now on being a provider, so to speak, one thing I know for sure is, if we start the conversation early—we are talking about intervention in our adolescence—one thing I know for sure is, if we have this conversation in our schools, 50 percent of our problems would go away, because what happens is two things.

One, we have an invalidating environment, and, two, our professionals, our teachers, our parents, they do not know how to identify and deal with it. So that is the first step: being able to start the conversation early and being able to equip our professionals with the things they need to be able to identify it.

You talk about tele-health. There are companies out there, like Lantern and Enjoyables and the X2AIs, where you can deploy resources to those neighborhoods that may not have professionals or a clinic, where we all have telephones. How cool would it be if we are in school and we may not have counselors, because we do not

have the budget for it anymore, or a professional, but you can do CBT with a clinician or dialectal behavior therapy or just self-assessment, where you are just talking about a day, instead of invalidating a kid and putting him in isolation, which turns to suicide.

Senator THUNE. I appreciate that perspective on that. I wanted, by the way, to say, Mr. Marshall, as a recognizable professional athlete, how much we appreciate your advocacy for people who struggle with mental illness, and especially for those who have not yet sought treatment.

Since you are a high-profile individual who is known for successfully pursuing treatment for mental illness, if you were going to suggest for somebody where they should start if they need help, particularly young people in some of those examples that you just mentioned where you have kids whose parents do not know how to identify it and teachers do not, where would you suggest they go?

Mr. MARSHALL. Mr. Thomas hit it. They have a program, Peer-to-Peer. The first place our children go to is their friends. So that is why we need to start the conversation, because when my son goes there—he is in elementary School—if he is having issues, if his friend is having an issue, they go to each other. Then what happens?

So I think there are many solutions, but one of the things that I always talk about is educating our kids. Project 375, we are working with this three-tiered program where we are teaching our children how to identify and how to talk about it, because that is what happens.

Even when you go to our young adults, the first outbreak is from the age of 18 to 24. That is on campus. That is peer-to-peer. The first person you go to is a friend or a loved one.

So that would be my answer. It is to start with the conversation. We threw around mental health first aid. I think that is really important not only in our school systems, but also when we talk about our police departments. How do we identify it? How do we deal with it? That is the first step.

Senator THUNE. Thank you for sharing your story. Thank all of you. By the way, we will be optimistic and say that when you play the Packers in the Super Bowl next year, take it easy on their secondary. [Laughter.]

Thank you.

Mr. MARSHALL. Thank you.

The CHAIRMAN. Senator Scott?

Senator SCOTT. Thank you, Mr. Chairman.

The CHAIRMAN. Senator, I have a whole office-full down there that has been after me, and I have been interrupted a few times. I apologize to you, because this is personally a very, very important hearing, and I definitely will pay attention to everything you have said.

I just want you to know this committee takes it seriously, and we are going to do some things here this year that hopefully will get us down the road a bit more. But I am fully aware of how much we need to do.

So we are going to turn it over to the last questioner, unless somebody else walks down, and if you will shut down the committee, I would appreciate it.

If I can just wave to you guys and just say how deeply appreciative I am that you could be here. I am sorry I have had so many conflicts, but the testimony I have heard has been just great.

Senator Scott?

Senator Scott [presiding]. Thank you, Mr. Chairman.

Thank you to all the panelists for being here this afternoon. It certainly is a very important issue that we are seeing, and there is a steady increase in interest around the country, which I think is really good news.

In South Carolina, we really have been on the cutting edge in the use of tele-psychiatry in our State. We have had, since 2009, about 27,800 mental health consultations that occurred using tele-psychiatry.

We think it is the future, frankly, in a number of areas in the medicine field, especially as you look throughout the States like South Carolina where the rural opportunities for access to health care and to mental health services are dwindling. They sometimes seems to be nonexistent.

I would love for the panelists to perhaps comment on the success and the opportunity for more innovation and creativity in the tele-health field, but specifically tele-psychiatry.

When you think about the fact that—my understanding is, when you are looking at it from an emergency standpoint, that the price point is about \$3,000 less per episode, which is an important part of a State's consideration. When you think about the individual, there is no doubt that providing access to quality health care when the person needs it the most, especially if you are living in a rural area, is so important that you need to think about tele-medicine.

So I would love to hear your comments on the use of tele-psychiatry and using the whole next iteration of the opportunities from a mental health and a health-care perspective.

Mr. MARSHALL. Well, it is funny, because Tuesday I actually spoke at Collision in New Orleans. It is a tech conference, one of the largest out there. And a couple weeks ago, I spent some time in San Francisco really trying to study this market, because I have been pounding the pavement for a couple years—and I know you guys have been working longer than me—but I have been really frustrated, because my goal is to put a clinician in every single school in America, but now I am finally realizing that that is almost impossible.

So a few mentors of mine have been telling me for a few years that we have to adopt technology. I will say this. It is not to replace, but to assist and also help stand in the gap. There is some amazing technology out there, and I think the reason why it is the solution, part of the solution, a big part of the solution, is because it is accessible, affordable, and scalable.

When you look at our problems now, we are having problems just getting our youth to take up psychology in school. So it would be impossible for us to take one human being and take on a workload of 200 patients, where we can take one tool—and I love what you just threw out there and what you guys are doing in South Caro-

lina—but you can take one tool and that one tool can treat or assist 2,000.

Senator SCOTT. Thank you. Are there any other comments? Then I have a couple more questions and only about 2 minutes left, according to—no longer according to the chairman, but according to the clock. Thoughts?

Dr. BENNINGTON-DAVIS. Senator Scott, I just would echo what Mr. Marshall said. I really like the way that he said assist, not replace. There is something about a human-to-human interaction that, in psychiatry, is particularly powerful.

That said, there are tremendous uses of tele-health. We are seeing it in dermatology, we have seen it in radiology for a long time, and it turns out that the next generation of people really like interacting through technology. So I think we are just seeing the tip of the iceberg.

Senator SCOTT. Thank you. I am going to move on to my next question to try to stay somewhat close to my 5-minute limit.

I would say that one of the areas where we are seeing a lot of emphasis is on our veterans. We have so many men and women who have donned the uniform, willing to sacrifice their lives on behalf of this country, on behalf of freedom, and sometimes they get back and it feels like our VA is failing so many of our veterans.

I know that at home, Scott Isaacks, who runs the Ralph Johnson VA location, has been one of the outliers, frankly, from my perspective. He has done a really good job of using tele-medicine and tele-psychiatry in a positive and powerful way to treat so many of our veterans.

Both of my brothers have served in the military, and my older brother, the unattractive one, has 32 years, has just retired from the Army, a command sergeant major, and focused on the war transition process.

Have you seen a collaboration between the VA and States on addressing some of the issues that our veterans have?

Ms. Rosenberg?

Ms. ROSENBERG. I was hoping you would not ask me.

Senator SCOTT. I am going to ask Mr. Thomas as well. So you can decide who goes first.

Ms. ROSENBERG. I will start. It is complicated.

Senator SCOTT. Yes, ma'am.

Ms. ROSENBERG. Is that a good way to say it? I think the VA often gets a bad rap. I think they do some very excellent things and some very fine work. Often, people are interested in the VA money more than they are interested in veterans, unfortunately. I am being very honest and very direct.

But that said, the VA is also a single-payer system and likes to keep control. So I think collaborations are difficult for them. I think they have made tremendous headway, and I think community organizations have worked very hard to create those partnerships.

I have seen some very good evidence, particularly in the area of the treatment of addictions, where there are some very good partnerships.

Senator SCOTT. Mr. Thomas?

Mr. THOMAS. With our VA, we also have Hill Air Force Base and then a large National Guard contingent in our State. We have

worked with all three really well around, in particular, suicide prevention and peer support and outreach.

Those have been the areas where we seem to be able to share a lot of the same ideological and policy directions with them. Our VA, the folks that we interact with, try hard to get—there is some of the stigma that Mr. Marshall talked about in that system, and if I say that I have a problem and get my services through the VA, what will that do to my career?

So I think the clinics that they have started out in the communities, where it does not go on your record, have been really helpful and a step in the right direction.

Senator SCOTT. Perhaps not for right now, but perhaps you can submit it for the record, if you have any shining examples of States where you believe that that coordination is occurring in the most effective way, I would love to hear from you. If you want to respond now, you can, but if you do not mind including that in perhaps a follow-up later, that would be wonderful.

My final question for the panel would be one of the economic impact of the untreated person. I think so often we think about the cost associated with care, the cost associated with treatment. Too often, I believe that we forget that there is a cost to not treating.

I am not quite sure how we monetize and/or figure out how to effectively figure out that cost, but I think we would be remiss if we did not spend a few minutes on the fact that without treatment, the human cost is incredible, and without treatment, the economic cost is measurable, but it is pretty dismal.

Final thoughts?

Dr. BENNINGTON-DAVIS. I will chime in, Senator Scott. We have already mentioned today the early death of people who have mental illness and substance use disorders. I would add the school dropout rates and the tremendous economic and human impact of not being able to be successful in school, and I think those are probably a good start.

Ms. ROSENBERG. I would add to that. If you look at children who have been diagnosed with a serious emotional disturbance, what you see is up to 25 percent of them wind up in jails and prisons. So we then have that cost.

I think additional to that, if you look at Social Security Disability and SSI, the biggest driver is mental illness. So you have lost income, lost taxes, lost wages.

I think it is quantifiable. Lack of treatment does cost us a lot of money as a country.

Senator SCOTT. Yes, ma'am.

Mr. Thomas?

Mr. THOMAS. I would just add, I think those are all the big economic costs, but I think the biggest cost is the tear in the fabric of our families and society, that that is the devastation that occurs when a family member loses someone, whether it is to jail or suicide or early death because of not getting treatment.

Senator SCOTT. Absolutely. Well, thank you.

Mr. MARSHALL. I was going to say Mr. Thomas took all of my words verbatim.

Senator SCOTT. Excellent. I would add that coming out of South Carolina, approximately 38 percent of those between the ages of 18

and 20 are unemployed and 53 percent between 21 and 64 are unemployed. So the impact of mental challenges, mental health and mental illnesses, when you quantify it, it is drastic.

Thank you all for being here and participating in the process of engaging members of Congress, as well as the public, on such an important issue. I want to thank you all for taking the time. As we have heard, this is an incredibly important topic, and frankly, one that we need to spend more time on.

I will continue to work with our colleagues on and off of this committee to address mental illness.

As for our witnesses, once again, please keep us informed on the great work that you all are doing. Thank you for the courage and the commitment to making a difference not only in our own lives and the lives of your community, but of our Nation. We thank you for that.

I would ask that any questions for the record be submitted by Thursday, May 12, 2016.

With that, this hearing is adjourned.

[Whereupon, at 4:20 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF MARGARET BENNINGTON-DAVIS, M.D.,
CHIEF MEDICAL OFFICER, HEALTH SHARE OF OREGON

Chairman Hatch, Ranking Member Wyden, honorable members of the committee, thank you for this opportunity to offer testimony on mental health services provided through the Medicaid program and Oregon's innovations in service delivery.

I have spent the better part of 30 years as a leader in the mental health services provider community in Oregon and abroad. I have worked as a mental health provider in the community and hospital settings, as a program administrator, and as a leader in organizational change. I have performed hundreds of consultations, both nationally and internationally, on trauma-informed care and the elimination of seclusion and restraints in psychiatric care settings. What I have learned in this time is that behavioral health—stable mental health and freedom from substance use disorders—is simply health. In other words, “health” requires not merely the absence of physical disease but a state of wellbeing in physical, dental, social, and mental health.

Currently, I serve as Chief Medical Officer for Health Share of Oregon, the State's largest Coordinated Care Organization (CCO). Health Share is a transformative model of Medicaid managed care that brings together local health plan, provider, and community organizations to coordinate physical, dental, mental health, and substance use disorder benefits for more than 25 percent of Oregon's Medicaid enrollees.

The CCO model was created by a Medicaid 1115 Demonstration Waiver 4 years ago, and Health Share was a new organization created specifically to fit that model. Even in this short time, the CCO model, which provides financial incentives for improving health care delivery, has allowed us to uncover data to support a simple truth about the population we serve: the most frequent and costly utilizers of Medicaid services are adults who experienced childhood trauma.

This discovery, and the CCO model in general, has brought new attention to and appreciation of the roles of mental illness and addictions in costs and poor health outcomes. As a result, there are initiatives in communities across the State to increase access to mental health and addictions services, integrate behavioral specialists into primary care, and ensure better primary care supports to people with serious mental illness.

In this testimony, I will: explore the promise of the CCO model; describe the impetus of Health Share of Oregon's decision to focus on access to services and promotion of early life health; provide examples of upstream interventions that Health Share believes will bend the cost curve in the long-term; describe the extant mental health system challenges that communities are addressing in Oregon and across the country; and comment on Federal policy challenges in the mental health and substance use disorder space.

MEDICAID COORDINATED CARE ORGANIZATIONS: THE PROMISE OF OREGON'S HEALTH SYSTEM TRANSFORMATION

Oregon's CCOs are regional Medicaid managed care contractors, each with a governance model that reflects its community and health services marketplace. Each CCO has at least one Community Advisory Council that is made up of a majority of CCO enrollees. All 16 CCOs have 2 things in common: they are all different be-

cause they each reflect the community they serve, and they share the goals of better care, smarter spending and healthier people. There are a number of programs and incentives designed to help CCOs obtain those goals, including but not limited to:

- Integration of physical health, mental health, oral health, non-emergency medical transportation, addiction residential services, and children’s wrap around services into each CCO;
- Withholding 5 percent of CCO budgets to be paid based on performance on robust set of incentive metrics;
- Requiring development of alternative payment methodologies and hosting “learning collaboratives” to spread successful models;
- Requiring CCOs to cover some “flexible services,” which are non-covered services that may be more cost effective alternatives to covered services (*e.g.*, vacuums for families whose children suffer from severe asthma; healthy meal vouchers); and
- Requiring CCOs to conduct regular community health needs assessments and implement community health improvement plans.

The CCO model is already showing signs of success. This program is expected to save the State and Federal governments \$1.7 billion on Oregon’s Medicaid program over the first 5-year demonstration.

Oregon made a significant promise to CMS when it signed the current Medicaid waiver agreement—that through the CCO model, our State would decrease the expected Medicaid spending trend by 2 percent over 5 years, not by cutting the number of individuals served or reducing provider payment rates, but by improving the way Medicaid services are delivered. CCOs did not have much time to make good on this promise, so we began with addressing the highest utilizing and most costly members.

THE NEED TO WORK UPSTREAM: WHAT WE LEARNED FROM
THE ADVERSE CHILDHOOD EXPERIENCES STUDY (ACES)

When Health Share analyzed those among our 240,000 members who used the most services and led to the highest costs, we began by asking them to describe their lives. The results were compelling. Very often these members were born into unstable housing and chaotic families, and to parents who did not intend to have children and were not ready or able to parent. Some had been in and out of the foster child system early in life; many had been sexually or physically abused. Most did not have childhoods that prepared them to be successful in school. There was often drug use and other high-risk behavior during adolescence. Often their drug use had led to brushes with the criminal justice system. Many became parents themselves when they were not yet ready or able to parent. Most had various erratic behaviors, depression, or suicidal tendencies that led them to require services in specialty mental health if they could get access, or to jails or hospitals if they could not. Many had never finished school, and many had more than one chronic physical condition.

This is exactly what the Adverse Childhood Experiences Study (ACES), published in 1998, revealed: there is a powerful relationship between adversity and toxic stress during childhood and our physical and mental health as adults, as well as the major causes of adult mortality in the United States.

We know that almost half of children in the United States grow up in poverty, which is an important social determinant of health and contributes to child health and developmental disparities. Growing up in a stable and healthy home, in a language rich environment, and having access to quality preschool and regular well visits to a medical home are all critical for developing social and emotional competencies in children as they prepare to enter school. Evidence also shows that kindergarten readiness and success is linked with later educational success, which in turn is associated with better health and economic outcomes.¹ In other words, if children are prepared mentally, emotionally, and physically for kindergarten, they are more likely to be healthy adults. To be effective parents, adults need to be healthy themselves. To be healthy, they need access to physical, mental, and dental

¹Jones, D, et al. (2015). Early Social-Emotional Functioning and Public Health: The Relationship between Kindergarten Social Competence and Future Wellness. *American Journal of Public Health*. Vol. 105, No. 11, pp. 2283–2290.

services. The cycle of poverty is one that we, in the health care community, have a role in ending.

Health Share of Oregon, in the face of such evidence, determined that if we are to move the dial on curbing Medicaid costs, we needed to move “upstream” in our efforts to improve health. We needed to build systems and communities that create effective parents and healthy, stable environments for children. To that end, Health Share is focused on helping our members: avoid unwanted pregnancies; access social, physical, and mental health supports during pregnancy; have their basic needs met in order to successfully be able to attach to their new babies; and get the support and guidance they need to be effective parents.

WHAT THE DECISION TO MOVE UPSTREAM MEANS FOR MENTAL HEALTH SERVICES

Community mental health services have traditionally focused on people who have already developed chronic and severe mental illness. By adding emphasis to early childhood supports and the social determinants of health, focusing on early intervention, partnering with schools, and paying attention to the availability of mental health supports within a community, perhaps we can mitigate the tragic long term effects of the toxic stress described in the ACE study.

Nationally, people with serious mental illness die on average 25 years sooner than the general public;² this statistic has been even more severe in Oregon.³ These early deaths are almost always because of chronic physical illnesses that are modifiable, with the right supports. Oregon’s CCOs are working hard to identify those “right supports.”

Senator Stabenow’s Excellence in Mental Health Act is key to identifying those “right supports” and is, in my view, one of the most important legislative initiatives addressing mental health since the 1960s. This legislation builds on the original Community Mental Health Act, which described the continuum of services required to move from institutional care for people with serious mental illness to the community. Senator Stabenow’s legislation now brings us to the important recognition that community mental health services also need to be providing or coordinating primary care because people with serious mental illness may not get health care anywhere else. Oregon is one of the eight pilot States, and improving care in community mental health centers fits in very well with the overall CCO model.

MOVING UPSTREAM FOR SPECIAL POPULATIONS: CREATING MEDICAL MODELS FOR CHILDREN IN FOSTER CARE AND ADDICTED MOTHERS

Designing Health Care Systems That Work for Children in Foster Care

Through analysis of our population data, which mirror national data, we know that children ages 0–6 in the foster care system have a much higher incidence of asthma, attention deficit disorder, PTSD, and obesity than children in Medicaid who are not in the foster care system. These differences persist in older children, with the addition of much higher incidence of depression, and by late teens/early adulthood, the addition of higher incidence of schizophrenia and hypertension. The most surprising finding for us was that these differences persist, and are even higher, in children who were in the foster care system at one time but are no longer involved in the child welfare system. In other words, the experience in the foster care system was not healing, and did not provide a safe way to ensure healthy development, either physically or emotionally. We as a society need to address the root of this issue by ensuring the right supports to parents in the first place, so they keep their children in safe and nurturing families. In the meantime, we at Health Share are also focusing on developing coordination among mental health, dental health, and physical health providers for these kids, and describing what the right supports are for them in those health care arenas.

In October 2015, Health Share launched the Foster Care Advanced Primary Care Collaborative with seven of our area’s clinics and clinic systems. The Foster Care APC is a year-long learning collaborative to explore and implement Foster Care Medical Home Models and interventions to better support the health needs of foster children. The collaborative consists of six half-day learning sessions held every other month that are focused on key population dynamics, such as identifying children in

²Parks, J., et al. (2006). Morbidity and Mortality in People with Serious Mental Illness. Alexandria, VA: National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council.

³(2008). Measuring Premature Mortality Among Oregonians. Salem, OR: Oregon Department of Human Services Addictions and Mental Health Division.

foster care, working with victims of abuse, neglect and trauma, understanding child welfare systems and processes, working with foster parents and biological families, coordinating with the mental health system of care, and more. Teams of four to eight staff from each clinic participate in each learning session. On the off months between learning sessions, a Steering Committee meets to help tailor the next session topic to meet needs identified by the clinics as they implement their models. The Steering Committee includes one representative from each clinic system along with a small group of local clinical and population champions from various organizations. These seven clinic systems together provide primary care to more than 1,000 foster children in Health Share's three counties and look to play an integral role in developing a system of care that meets the unique needs of this vulnerable population.

Project Nurture: Serving Pregnant Women With Substance Use Disorders

Another example of a special population that requires our immediate attention if we want to improve the health of future generations is pregnant women with substance use disorders. There are obvious fetal development risks involved with pregnant women battling addictions. These risks can be mitigated with proper treatment, but these women need to feel safe accessing appropriate medical care. To that end, Health Share funded the development of, and continues to support, a program called Project Nurture.

Project Nurture provides prenatal care, inpatient maternity care, and postpartum care for women who struggle with addictions, as well as pediatric care for their infants. Women who are enrolled also receive Level 1 outpatient addiction treatment by certified alcohol and drug counselors (CADCs), and Medication Assisted Therapy (MAT) using methadone or buprenorphine when indicated. Project Nurture's model is to engage women in prenatal care and drug treatment as early in pregnancy as possible, provide inpatient care for their delivery and follow them and their infants for a year postpartum providing case management and advocacy services throughout. Women who participate in Project Nurture are informed of policies regarding Child Welfare reporting and we believe that this transparency facilitates a trusting relationship with providers and allows us to advocate for women and their families whenever possible.

THE IMPORTANCE OF HEALTH COVERAGE TO IMPROVING MENTAL HEALTH IN AMERICA

Oregon was also an early adopter of Medicaid expansion under the Affordable Care Act (ACA). This was crucial for people with serious mental illness in our State. Without insurance coverage, people could not access community mental health services except for crisis, ERs, and hospitals—the least efficient and effective times and ways to aid recovery, and the most expensive. Nearly everyone in Oregon now has better access to services, and sooner. Things are looking up for people best served in community mental health settings, but we still have a long way to go.

MENTAL HEALTH SYSTEM ISSUES: LEVELS OF CARE AND WORKFORCE CHALLENGES

One Size Does Not Fit All: Levels of Care in Community Mental Health

Even with nearly universal health coverage in Oregon, access to specialty mental health services is still not necessarily smooth or easy, and the array of services are not as broad and varied as is necessary for optimal health. A contributing factor is glaring holes in availability of certain types of mental health services along the spectrum of levels of care for people with mental illness.

Most community mental health services are office-based outpatient programs. Many people with serious mental illness need more intensive supports initially, and then episodically thereafter.

Intensive outpatient and assertive community treatment (ACT) models offer to literally meet the person where they are, at whatever hour works best for them (a lot of people served in community mental health centers are homeless or without transportation). ACT teams, sorely lacking in many States, including Oregon, are multidisciplinary teams that are on call to the individual 24/7, and help with myriad social supports in addition to psychiatric support. Although these teams require significant up-front investment, it is clear that they are extremely effective and ultimately cost-saving for people who otherwise cannot engage in traditionally administered clinic-based services, and who end up using the most expensive settings—EDs, jails, and hospitals—as their default service systems. Health Share is proud to have funded for our community what we believe to be the first forensic ACT team in the United States—designed specifically for people with high engagement with the criminal justice system.

Independent housing, supportive housing, supported education, and supported employment are also key components of a highly functioning community mental health system. The CCO model was intended to allow Medicaid managed care entities to expand payment for these types of services, which are not traditionally covered health care services. Oregon's CCOs are still learning how to best provide access to these necessary services without reducing payment rates that are largely based on utilization of traditional medical services.

Provider Workforce Challenges

There is a shortage of psychiatrists nationally, including in Oregon; 59 percent of psychiatrists are 55 or older, and not enough physicians are being trained. Federal health authorities have designated 4,000 areas in the United States as having insufficient access to psychiatry—areas with more than 30,000 people per psychiatrist. We need to train more psychiatrists.

In community mental health, workers are often entry-level and overworked. Once experienced, they move on to private practices or hospital settings for better pay and better working conditions. We need to make community mental health more attractive workplaces.

In addition to training more psychiatrists and improving working conditions in community mental health centers, we need to broaden our idea of who provides care (including peers and community health workers) and what that care looks like. The mental health provider community is only just beginning to understand the tremendous power of peer supports in mental health treatment. People with lived experience of mental illness and recovery are often the best coaches and system navigators; they expand the workforce, give relief to over-taxed professional teams, and are extremely effective and well-liked by those they serve. Our systems are working to integrate peers into treatment settings and teams, but there is work to do. Specifically, CCOs and other payers need to develop payment models to support these types of workers.

One program that Health Share has implemented in an attempt to address workforce challenges is Project ECHO. This is a tremendously successful “tele-mentoring” model developed by Sanjeev Arora, M.D. at the University of New Mexico to upskill primary care providers to be able to provide treatment to people with Hepatitis-C. Health Share, in cooperation with one of our founding organizations, Oregon Health and Science University (OHSU), brought the ECHO model to Oregon. Instead of using the model to train PCPs in treatment of HCV, we began by using the technology to train PCPs in psychiatric medication management. Oregon, as noted above, suffers from a shortage of psychiatrists. We used the ECHO model to bring teaching and consultation from psychiatrists to PCPs serving our members and, eventually, across the State. Building on that success, we started a second ECHO model this year, which is upskilling PCPs in developmental pediatrics, teaching them to screen for and treat developmental issues, such as trauma, ADHD or autism.

MEDICAID PAYMENT AND POLICY ISSUES: THE IMD EXCLUSION, MENTAL HEALTH PARITY, AND 42 CFR PART 2

IMD Exclusion

Experts agree that limiting institutionalization is an important policy goal. Oregon remains a national leader in providing long-term care services in home and community settings. However, it seems that the “IMD Exclusion”—the part of the Medicaid rules that prohibits use of Medicaid dollars for adult stays in “institutes for mental disease”—has lost its utility, at least in the context of limiting institutionalization.

The Supreme Court decision in *Olmstead v. L.C.* makes it clear that under the Americans with Disabilities Act (ADA), States are generally required to provide care in a community-based setting provided that the “State’s treatment professionals have determined that community placement is appropriate, the transfer from institutional care to a less restrictive setting is not opposed by the affected individual, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities.” Repeal of the IMD Exclusion would not be expected to adversely impact efforts to establish community based care for, but rather to assure appropriate treatment for, those individuals needing care in an IMD.

In its recently released final Medicaid managed care rules, CMS partially lifted the exclusion for certain brief lengths of stay (15 days within a calendar month, up

to 30 consecutive days over 2 months). CMS reasons the increased flexibility is warranted by a decline in the number of inpatient psychiatric care facilities and concerns about access issues for those who need inpatient care, and psychiatric boarding in emergency rooms. The limited length of stay, CMS reasons, would preclude the use of IMDs for long-term care, indicating that Medicaid is trying to balance the need for inpatient psychiatric beds with a desire to limit institutionalization.

For consumers, this provides more options if hospital-based care is needed. For provider organizations, this change would offer the opportunity for acute care programs with 16 or more beds to participate in the Medicaid program—and to offer more robust crisis response programs and alternatives to hospitalization.

A full reversal of the IMD exclusion is likely not fiscally practical, but revising the law even further could give providers better incentives to ensure access to the right level of care at the right time.

Allowing States to apply for waiver authority to exclude substance use disorders facilities from the IMD exclusion was a step in the right direction. The length of stay in an acute setting that is necessary for effective treatment of substance use disorders is typically longer than that needed for treatment of mental illness in an acute setting.

Allowing Medicaid payments for IMDs with average inpatient stays that exceed the current 15 day limit, such as 30 or 60 days, would be a stepwise approach to ensuring better access for Medicaid enrollees. Congress could also narrow the definition of IMDs to facilities with more than 30 or more psychiatric beds. These approaches would leave the IMD exclusion itself in place while making access to short-term inpatient care more accessible.

Mental Health Parity

Oregon was very early to ensure parity in access to mental health benefits. Part of what makes Oregon's Medicaid program unique is that in times of economic hardship for the State, rather than limiting the number of eligible Oregonians Medicaid can serve, we choose to use a public, deliberative, and evidence-based process to limit the benefit package, which we call the Prioritized List of Services. For more than 20 years, mental health conditions have been ranked amongst physical health conditions on the prioritized list. However, there are still non-quantifiable issues of parity—the need to be quite advanced in symptoms before getting access to specialty mental health and a high threshold for Medicaid enrollees to access hospitalization (dangerous to self or others). Truly effective parity still needs definition.

42 CFR Part 2: Privacy Protection and Sharing Information in a Coordinated Care Environment

Sharing pertinent health care information about our members is fundamental to providing truly coordinated care. We appreciate the concerns that lingering stigma about behavioral health issues, and substance use disorders in particular, raises for our members. Patients' trust is fundamental to their acceptance of treatment, so privacy is a particular concern for people receiving treatment for addictions. That said, SAMSHA's regulation, 42 CFR Part 2, which prohibits providers and health plans from sharing information about substance use disorder diagnoses and treatment plans with each other—and goes well beyond the privacy protections afforded to other health services through the Health Insurance Portability and Accountability Act (HIPAA)—restricts the sharing of information in a way that is detrimental to the people receiving treatment. As the greater health care community has shown through HIPAA, we are capable of limiting the sharing of information to what is absolutely necessary to provide the best possible care. We are encouraged by SAMSHA's current proposed regulations and hope to move to a regulatory environment where substance use disorder diagnosis and treatment information is treated like any other personal health information.

THE FUTURE OF MENTAL HEALTH IN AMERICA LOOKS BRIGHT, BUT WE HAVE WORK TO DO

I am proud of what we have already accomplished at Health Share of Oregon, and I believe that this regional, collective impact model could work in any community and with other health care payer types. Looking upstream to social determinants of health, including poverty, and preventing trauma and chronic stress in childhood will reduce the incidence of all illness—both physical and mental. I encourage Congress to continue to support the kind of flexibility in the Medicaid program that allows States like Oregon to improve the health of our population and lower costs by

focusing on prevention rather than the volume of services used to treat people once they are already ill.

PREPARED STATEMENT OF HON. ORRIN G. HATCH,
A U.S. SENATOR FROM UTAH

WASHINGTON—Senate Finance Committee Chairman Orrin Hatch (R-Utah) today delivered the following opening statement at a hearing to examine various options on how to address mental health issues in the American health care system:

It is a pleasure to see everyone here today.

Today's hearing will focus on mental health issues in America and the role the Medicaid and Medicare programs play in addressing the needs of those with behavioral and mental health issues. Together, Medicare and Medicaid finance nearly 45 percent of mental health spending in the United States, which amounted to more than \$75 billion in 2014 alone.

As the Senate committee with jurisdiction over these programs, it is our responsibility to better understand the drivers behind the growing needs for and costs of these services and to work together to develop better solutions for identifying and treating these issues.

A report issued by the Medicaid and CHIP Payment and Access Commission in June 2015 indicated that the majority of Federal spending on mental health comes out of Medicaid. That same study found that Medicaid is the single largest payer in the United States for all behavioral health services, including mental health and substance abuse. In fact, Medicaid accounted for 26 percent of nationwide spending on behavioral health in 2009, the year with the most recent data.

One of the many difficulties we face in addressing these issues is that Medicaid enrollees with behavioral health diagnoses have varied physical and behavioral health needs. Patients often range from young children who need screening, referral, and treatment for autism or depression to chronically homeless adults with numerous diagnoses including severe mental illness.

In 2011, only one in five Medicaid beneficiaries had a behavioral health diagnoses, but they accounted for almost half of total Medicaid expenditures.

Needless to say, these types of behavioral health issues can seriously impair a patient's quality of life, cause disability, and significantly decrease life expectancy. These types of issues are associated with significantly higher rates of chronic disease, substance use disorders, and inpatient hospitalization among Medicare beneficiaries.

And, in Medicaid, patients with behavioral or mental health diagnoses are more than twice as likely to be hospitalized as those without such diagnoses. The number is drastically higher if the patient also has a substance use disorder.

These high hospitalization rates are major drivers in the cost of our Federal health programs. However, what is more unfortunate is that all too often people with mental or behavioral health issues get no care at all.

According to the 2012 National Survey on Drug Use and Health, nearly 40 percent of adults diagnosed with severe mental illness—such as schizophrenia or bipolar disorder—received no treatment for their illness in the previous year. When you broaden that scope to include all adults with any mental or behavioral illness, 60 percent went untreated for the prior year.

It gets worse.

Every year, suicide claims the lives of 38,000 Americans—more than car accidents, prostate cancer, or homicides. And, about 90 percent of suicides are related to mental illness, according to the National Institute of Mental Health. Utah is not immune from this preventable tragedy. Suicide has been the greatest threat to our young people in recent years, and it is time for everyone to take notice.

This is absolutely tragic. However, the tragic pattern expands beyond the suicide rate as, overall, people with serious mental illness have an average life expectancy that is 23 years shorter than the nationwide average.

Patients and their advocates say the country's mental health system has been drowning for a long time—not from floodwaters but from neglect.

As we talk about solutions, we need to note that the distinction between mental health, mental illness, and severe mental illness is crucial, because each group requires different clinical and policy prescriptions. For example, the current system, proportionally speaking, provides far more support for mental health than severe mental illness. We need to review these priorities and find an equitable solution to ensure that all needs are being met.

Today's panel will give us an opportunity to hear from witnesses who can speak to these issues from almost every perspective. We have an advocate who has suffered with these issues firsthand. We also have experienced professionals who will share their experiences providing care at the local, State, and Federal levels and who can speak to the successes and limitations of providing care in each of those environments.

I look forward to hearing the testimony of today's witnesses and beginning a dialogue with my colleagues on these important issues that, hopefully, will lead to better solutions.

PREPARED STATEMENT OF BRANDON MARSHALL, EXECUTIVE CHAIRMAN
AND CO-FOUNDER, PROJECT 375

Thank you, Mr. Chairman, Ranking Member Wyden, and members of the committee. I'm grateful for the opportunity to speak before the U.S. Senate Finance Committee on an issue which not only affects me, but millions of people across America: the impact of stigma in the mental health community, and the critical need to make it easier for people to get assessed and treated and be able to lead a normal, fulfilled life.

My name is Brandon Marshall—father, husband, son, friend, a man of faith, wide receiver in the NFL, and co-founder with my wife Michi Marshall of the nonprofit Project 375. Our mission is to end the stigma surrounding mental illness, fostering open dialogue that encourages people to recognize symptoms and seek help.

As a public figure, my actions have been in the spotlight for years, both on the gridiron and off. I was diagnosed with Borderline Personality Disorder in 2011. Before then, as many people may know, my life was a living hell. Yet I didn't know why. It was hard to control my emotions and manage my life effectively, and the situation was only magnified by the tough-it-up culture of football.

For me, the tipping point came when I became so isolated and depressed that I stopped talking to my wife and family. I descended further and further, but it simply felt like the new normal. What the tabloid headlines said wasn't the true reality of my suffering—the isolation and depression were.

Finally, I was persuaded to visit McLean Hospital near Boston and got evaluated in a supportive environment where I felt people actually understood me. Just getting the diagnosis made me feel 50 percent better. And getting the right treatment plan transformed my life.

Why did it take so long to get help? The biggest factor was the stigma surrounding mental illness. I saw how ashamed others felt. This was what motivated me and my wife to launch Project 375. The journey I went through was difficult. I wanted to help others take that first step, the hardest one to take. By many accounts, I am the first public figure to stand up and publicly admit to the world a diagnosis of BPD. Going public was hard. It's no less hard for others struggling with undiagnosed mental illness.

In football, there's stats—lots of them. People obsess over the stats. My fans can rattle off mine. Here are three:

- I hold the record for most receptions—21—in an NFL game.
- I'm one of only five players in NFL history to have at least 100 receptions in three seasons.
- I hold the NFL record for most receiving touchdowns in a single Pro Bowl game.

In the realm of football, those numbers are impressive. But there are other stats that should make more of an impression on everyone here today. Here are 10 of them:

- 1 in 3 people will experience a psychiatric disease in their lifetime.

- Over 60 million Americans are afflicted by mental illness during any one year.
- The suicide rate has risen over 24 percent since 1999, making mental illness one of the only illnesses that has seen an increase in mortality rates.
- An estimated 17 million youth in the U.S. live with a psychiatric disorder, more than the number of children with cancer, diabetes and AIDS combined.
- Anxiety disorders are the most common mental illness, affecting close to 18 percent of adults in the U.S.
- Among the 20 million American adults who experience a substance use disorder, more than 50 percent have a co-occurring mental illness.
- Nearly 8 percent of Americans will experience PTSD at some point in their lives. People who suffer from PTSD are nine times more likely to experience issues of drug and alcohol abuse and dependence.
- Mental illness is associated with increased occurrence of chronic diseases such as cardiovascular disease, diabetes, obesity, asthma, epilepsy, and cancer.
- According to the American Psychiatric Association, while awareness of mental illness is increasing in the United States, there is a worsening shortage of psychiatrists.
- One silver lining: Many Americans do not understand that common mental illnesses can be successfully treated most of the time, including a 70 to 80 percent success rate for treatment of depression.

The prevalence of mental illness in the United States is reflected across society: from homelessness to incarceration to suicide. Often it goes unreported, or simply unnoticed, until it claims the life of a well-known figure, such as Robin Williams. The stigma surrounding mental health issues is our last great fight on this frontier.

Ask yourself: would you feel ashamed being diagnosed with cancer? No, of course not. With the first symptoms you'd get diagnosed and treated, whether through surgery, radiation or chemotherapy. Would you be afraid you'd be fired from your job if you were diagnosed with HIV/AIDS? We've conquered that frontier—the answer is no. However, many people still wonder: Are you sure you won't be fired if you're diagnosed with Bipolar II or BPD? Would your child be invited to a birthday party or sleepover if he or she is diagnosed with anxiety disorder, OCD, or maybe schizophrenia?

A staggering 75 percent of those who need help do not seek it because of the stigma. Because they fear what others may think, and how it may negatively impact them. Without help and treatment the consequences are dire—unemployment, incarceration, substance abuse, and even death. According to Dr. Scott Rauch of McLean hospital and a board member of Project 375, people are still hiding in corners, avoiding treatment, fearful of being labeled, afraid of losing their jobs.

I founded Project 375 with my wife out of our shared pain—and an understanding that millions of others could be helped by my stepping into the light. Talking about my BPD was liberating, but it was also scary—because of the stigma, I could have lost everything. Every time we release a video, send a tweet or publish a post, we hear from people who were inspired to finally take that step forward, to seek help, and to share their story.

We need to provide health coverage for brain illnesses in the same way we would any other physical illness or, in other words, treat the brain like we would any other organ in the body, making “Check Up from the Neck Up” part of routine exams, so we normalize treatment of mental health and addiction. We must accept mental illness as a disease, and like any other disease, it needs better research, screening and funding. We need better recognition of new therapeutic treatments that are proven to work. We need more robust education in schools, the enlightened support of news and entertainment media, and the advocacy of high-profile figures, like myself, willing to step forward. None of this happens if we still remain silent about these issues!

As an NFL wide receiver, I've caught hundreds of passes during my career. Today, I'm throwing one, to you. Thank you.

PREPARED STATEMENT OF LINDA ROSENBERG, MSW, PRESIDENT AND CEO,
NATIONAL COUNCIL FOR BEHAVIORAL HEALTH

Thank you to the members of the committee for inviting me to be with you today. On behalf of the National Council for Behavioral Health, I appreciate the opportunity to talk with you about the challenges and opportunities facing our mental health system.

Last week, the Centers for Disease Control and Prevention released data showing a steady growth in suicide rates in the United States each year since 1999, increasing by 25 percent in the last 15 years. Deaths by suicide are rising among adolescents and youth . . . among middle-aged Americans . . . and among older adults.

This news was especially difficult for me because I serve on the Executive Committee of the Action Alliance for Suicide Prevention. Despite growing attention to the issue of suicide prevention, our Nation hasn't been able to move the needle. Shining the spotlight of public attention into the shadows of mental illness is not enough.

There is rising public attention everywhere we look. This week, the *New York Times* featured a story about the Portland Police Department's efforts to improve how they handle crises. As Portland's police chief put it, "we are working in the backdrop of a fractured mental health system that has gotten worse and worse."

Talk of mental health and addictions has reached the presidential campaign trail, where candidates are making the issue a major platform of their campaigns. Governor Kasich, whose brother has been diagnosed with schizoaffective disorder and whose home State of Ohio saw more than 2,700 residents die of a drug overdose in 2014, has called for more services. And on the other side of the aisle, Hillary Clinton has released a comprehensive plan to address treatment and recovery.

Six hundred thousand Americans have taken a Mental Health First Aid course. The public is hungry to learn how to recognize the signs of mental illness, to be able to respond in an emergency, and to know where you can get help. Teachers, first responders, veterans, clergy, construction crews—the demand continues to grow.

So, yes, everyone—from Portland cops, to the candidates for President, to friends and colleagues—is talking about mental health and addictions. But as the numbers show, it is not enough. It's not enough for the more than 41,000 Americans who died by suicide last year. It's not enough for the more than 28,000 who died from an opioid overdose.

It's not enough, but not because of stigma, and not because we don't know what works in preventing these tragic deaths. It's because of how rarely those interventions are available—across settings—to reach people in their moment of need.

Life-saving treatments are too often delivered through Federal, State or local grants. When patients have cancer or heart disease, getting access to chemotherapy or a stent doesn't depend on their local clinic having a grant that targets those conditions. Treatment for mental illness and addiction should be no different.

Today, Congress has the opportunity to change the course of millions of lives. The question before you is not, "where are we now?" but "where do we need to be?" To get there, we need to move from talk to action: from raising awareness to connecting people with help. Here's how we can do it:

- **Access:** Expand access to a full continuum of services delivered in the context of robust and sustainable community-based delivery systems.
- **Science-based care:** Invest in evidence-based services, delivered by a skilled workforce that leverages technology and is held accountable for outcomes.
- **Integration:** Ensure mental and physical health care is integrated, services are coordinated, and high-need, high-cost populations are targeted.

Access. To answer the question of "where do we need to be?" let me begin with the issue of the shortage of psychiatric hospital and residential beds. Currently, the Medicaid Institutes for Mental Disease (IMD) exclusion makes it difficult for inpatient and residential facilities to expand. This has led to proposals to eliminate the IMD exclusion entirely or raise the permitted number of beds.

In some communities there is a need for more beds, and these inpatient facilities represent an important part of the spectrum of care. However, at their core, these services are designed to help people experiencing a sudden and severe deterioration of their health. Inpatient services will never be fully effective in a vacuum. Instead,

they must be delivered in the context of a continuum of care. Only community-based services can prevent re-admissions, trauma, and disruptions to home and work. At a time when we are growing Accountable Care Organizations and Medical Homes, beds aren't enough.

That's why the National Council is so proud to support the Excellence in Mental Health Act, which enables and sustains quality community treatment systems, and facilitates the coordination of care across health care settings.

The Excellence Act demonstration established criteria for Certified Community Behavioral Health Clinics (CCBHCs) that provide mental health and substance use services and primary care screening—along with care coordination. When care in a different setting is needed, CCBHCs coordinate with that facility to ensure seamless transition into and out of care. CCBHCs must also collaborate with schools and justice systems to keep individuals out of jail, at work, and in school. In turn, organizations that meet the criteria to be a CCBHC qualify for a Medicaid reimbursement rate that supports expanding services, serving new populations, and engaging patients and families outside the four walls of their clinics.

The comprehensive array of services envisioned under the Excellence Act includes crisis services. There has been talk in policy circles about investing in crisis services, and for good reason: timely access to high-quality crisis care can be the difference between an individual getting the intervention they need and that same individual ending up in the emergency room, jail, or worse.

This is not the first time crisis services have gained prominence in our policy debates—they were also touted in the 1980s as a way to alleviate the burden on overcrowded, understaffed hospitals. Crisis respite centers opened but many, funded by grants, struggled to survive. And, just as with psychiatric hospitals and residential facilities, standing alone, they were not enough.

The integration of crisis care into broader community-based delivery systems is a cornerstone of the Excellence Act, with CCBHCs required to directly deliver 24-hour crisis care (including mobile teams). CCBHCs must also coordinate with law enforcement and criminal justice agencies to ensure they're supporting public safety officers who too often are first responders to a psychiatric crisis.

Importantly, CCBHCs must also coordinate with veterans-serving agencies. As members of our armed forces return from Iraq and Afghanistan, rates of post-traumatic stress disorder and traumatic brain injury are on the rise. Unfortunately, too many veterans cannot access the services they need, in some cases because VA facilities are overburdened or simply inaccessible. CCBHCs are tasked with providing culturally competent care to veterans and members of the armed forces, and are responsible for coordinating that care with other agencies that serve veterans.

The integration of crisis care with community-based care envisioned in the Excellence Act could transform the way people access crisis services in this country—it could quite literally save lives. Unfortunately, it won't be available to all Americans.

Under the Excellence Act demonstration, 24 States are currently planning the comprehensive mental health service reforms that will allow them to certify, pay, and monitor CCBHCs. Yet, the law sets an 8-State limit on those who may ultimately participate—meaning that two-thirds of the planning States will have to stop in their tracks. Every State that wishes to create and sustain quality service systems should be able to do so, and that's why the National Council urges you to allow all 24 States to participate in the demonstration.

Science-based care delivered by a skilled workforce with the support of technology. To get our Nation's mental health and addiction services to where they need to be, it's not enough to expand access—we must ensure that services are high-quality, evidence-based and delivered in a way that both enables us to measure what's working (or what isn't) and holds us accountable for outcomes.

Unfortunately, the adoption of practices based upon the best available research is limited by a reliance on grants. For example, recent data from the NIMH Recovery After an Initial Schizophrenia Episode (RAISE) study showed the effectiveness of a multi-pronged intervention for individuals experiencing their first episode of psychosis. The intervention included evidence-based practices such as cognitive behavioral therapy along with medication, family psychoeducation, case management, supported education and employment. Despite research here in the United States and around the world, and the allocation of block grant funding, it's not enough. Most communities will be unable to implement the requisite interventions and tens of thousands of young people will be relegated to a life of disability.

Certified Community Behavioral Health Clinics hold the promise of expanding Americans' access to science-based care. CCBHCs are required to offer evidence-based services to meet the specific needs of their communities—and they can be paid a rate inclusive of these activities. Through data tracking and outcome monitoring, clinics will be held accountable not just for delivering these services, but for measuring patients' progress and adjusting course when treatments aren't working as hoped. Clinics that do well will be rewarded with quality bonus payments, another step in our Nation's move toward linking payment with performance, toward much discussed value-based purchasing.

But a key challenge to delivering timely, high-quality services lies in our Nation's shortage of mental health and addiction treatment professionals. The behavioral health workforce needs additional capacity and support to fully meet Americans' need for services. Texas, Iowa, Indiana, Idaho, Nevada, and Wyoming all have fewer than 6 practicing psychiatrists per 100,000 people—in fact, a mere 34 psychiatrists practice in the entire State of Wyoming. Just last week, I spoke with a medical director at a clinic in Texas who has been trying for more than 3 years to recruit a child psychiatrist. His situation isn't unique. Clinics all over the country struggle to recruit and retain staff.

One way Congress can help is by permitting licensed mental health counselors and marriage and family therapists to directly bill Medicare for their services. Technology can also help, playing a crucial role in extending the workforce. Using state-of-the-art streaming video technology, staff can connect with patients to adjust medications, deliver cognitive therapies, and educate and support children and parents. Online treatment platforms such as myStrength help patients manage in their daily life. Mental health and addiction organizations can be helped to adopt electronic health records—a proposal that has received strong bipartisan support—to better track patient outcomes, facilitate the exchange of health information, and coordinate care.

But the fundamental limitation underlying all discussions on the workforce is that most clinics cannot afford skilled staff or the necessary ongoing investments in technology. Those of you on this panel who have ever run a business know this is unsustainable—and it's no way to successfully treat Americans with mental illness and addictions. If we are ever going to alleviate the workforce shortage, we need clinics to be able to afford to hire the right staff and pay them what they deserve. And we need sustainable financing mechanisms that reimburse providers at a rate inclusive of technology costs.

The Excellence Act demonstration offers certified clinics a Medicaid payment rate that bears a rational relationship to the costs they incur. Under the Excellence Act, clinics will be able to hire critical staff—including psychiatrists, midlevel professionals and peers—and leverage new technologies to further extend the reach of those clinicians. They will be able to do this because they will receive a sound, predictable and sustainable payment rate that—unlike grant funding—supports the full array of activities of a high-performing clinic and does so in a way that will continue into the future.

Integration. Data show that individuals with serious mental illness have an average age of death at 53, the same as the U.S. life expectancy in 1917. The primary drivers of that early mortality are preventable and/or treatable chronic conditions like heart disease, lung disease, and cancer. Data also tells us that people with chronic physical illnesses often have co-morbid mental illnesses, especially depression and anxiety, that lead to poor health outcomes. Integrated care improves outcomes for both groups.

Earlier this month I had a first-hand experience with integrated care. On a Sunday, I went to an urgent care clinic. Unbeknownst to me, that urgent care clinic was part of an Accountable Care Organization that also included my primary care physician—which I discovered upon showing up at her office on Monday and finding out that they already knew all about the problem that had brought me to urgent care! They had access to my electronic health record and knew what treatment I had received. When my primary care doctor ordered a sonogram, the ACO followed up with a phone call asking if I'd like to use their sonogram provider. That's smart business AND it's good care. The two can, in fact, go together.

Unfortunately, my experience is still all too rare. Far too few health care organizations are equipped to fully coordinate and integrate care in such a way that every patient could reap the benefits I did. But behavioral health is aware of the need to better integrate care, and we are at a tipping point. The Excellence in Mental

Health Act, through its creation of CCBHCs, represents a foundational opportunity in the behavioral health safety net to advance the way care is integrated and coordinated.

CCBHCs are required to provide basic primary care screening and monitoring to all their patients, with referrals to and coordination with local primary care providers. In this way, they help reverse the trend of early mortality due to preventable causes among people with serious mental illness; and help primary care providers better address their own patients' ongoing mental health needs.

We know through the SAMHSA Primary Care-Behavioral Health Integration program, which has been funded by Congress since 2009 and has served over 70,000 Americans, that investing in integrated care improves health and reduces costs. For example, after one year in the PBHCI program, results from one grantee site in Travis County, Texas indicated patients had 618 fewer emergency room visits and spent 155 fewer days hospitalized. These outcomes resulted in \$1,193,000 saved in a year.

These results were from one clinic operating under a time-limited grant. Just imagine what we'll see when the Excellence Act demonstration's CCBHCs start their operations in January of next year.

Conclusion. The question before you is not, "where are we now?" but "where do we need to be?" Shining the spotlight of public attention into the shadows of mental illness is not enough. We need to move from talk to action and from pockets of excellence to the widespread availability of effective interventions.

The Excellence in Mental Health Act—CCBHCs—is where our mental health system needs to be—financially sustainable continuums of evidence-based treatments supported by and integrated with primary care, 24/7 high-quality crisis services, and a revitalized behavioral health workforce. That's what we can call reform.

PREPARED STATEMENT OF DOUG THOMAS, DIRECTOR,
DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH, STATE OF UTAH

Chairman Hatch, Ranking Member Wyden, and members of the committee, my name is Doug Thomas; I am the Director of the Division of Substance Abuse and Mental Health in the State of Utah and I am honored to be here with you today along with these distinguished guests.

Medicaid is the backbone of the public mental health system in Utah and throughout the United States. It provides the infrastructure and economy of scale necessary for States to standardize evidenced based practices to provide high quality care to individuals with serious mental health needs. The various Medicaid waivers and alternative benefit plans available to States allow them needed flexibility to customize plans to fit the unique challenges, needs, and resources of each State. Case Management, Peer Support Services for individuals and families, Psychosocial Rehabilitation and Respite services are great examples of Medicaid reimbursable services that help people stay in their communities despite serious illness and allow people the opportunity to reintegrate in place of being alienated from their families and communities of origin.

In 2009 the Institute of Medicine (IOM) issued a lengthy publication about the prevention and early intervention of mental, emotional and behavioral (MEB) disorders. The report highlights that almost one in five young people have a MEB disorder at any given time and that "among adults in the United States, half of all of these disorders were first diagnosed by age 14 and three-fourths by age 24." First symptoms usually precede a disorder by 2 to 4 years giving us a window of opportunity. Narrowing the gap between the onset of symptoms and evidenced based intervention is critical as the research is showing us that this early intervention preserves executive functioning and allows people, especially young people and people suffering from the first-episode of illness to recover more quickly with less life disruption. This allows them to accomplish and maintain important developmental tasks, such as "establishing healthy interpersonal relationships, succeeding in school, and making their way (into and succeeding) in the workforce." For young people with Medicaid we are able to intervene early with positive outcomes showing that people can and do recover from mental illness. Treating a person's mental illness improves physical health outcomes and reduces overall healthcare costs as well. There have been various Medicaid and other Health systems studies which show that collaborative physical and mental health care lowers costs and improves

health outcomes. In Utah 3 years ago with a new State Legislative Appropriation and County matching funds we began to act on the IOM report with what we call Mental Health Early Intervention. This consists of three programs, School Based Behavioral Health, Mobile Crisis Outreach Teams for Youth in four of our five most populous Counties and Family Resource Facilitation With Wrap-Around to Fidelity. Over the last 3 years we have increased services to almost 5,000 more youth, the majority with Medicaid funding. Office Disciplinary Referrals are down, Literacy scores are up, symptoms of mental illness are being reduced often to the community norm, and families are receiving the supports they need to keep their children safely at home, in their own school, and enhancing their family's natural support system through Peer Support.

Utah recently passed a limited Medicaid expansion designed to target people with the lowest income in the greatest need, parents with dependent children already on Medicaid, people who are chronically homeless, people with mental illness and substance use disorders involved in the criminal justice system and people with mental illness and substance use disorders. We must have Medicaid work with us to find a way to approve a waiver allowing Utah to extend Medicaid coverage to these additional people in need.

People want to be served in the safest, least restrictive environment and providers want to provide these types of services. Sometimes children and adults need care beyond what can be provided appropriately in an outpatient or home like setting. Allowing Medicaid residential services the ability to bill and be paid for room and board would be a great step in the right direction. Room and board is covered during a more costly inpatient hospital stay, but not covered during a more economical residential stay. This disincentivizes local, lower cost, short term residential services in lieu of more costly inpatient hospital care.

With the Patient Protection and Affordable Care Act, The Mental Health Parity and Addiction Equity Act and more integrated care being provided there is a need to modernize the Medicaid Institutes for Mental Diseases (IMD) Exclusion. I applaud the efforts of the Substance Abuse and Mental Health Services Administration, Centers for Medicare and Medicaid Services and the Department of Health and Human Services to modernize rule, including the option of State waivers around the IMD exclusion. It must be done cautiously and systematically to ensure we are not re-institutionalizing people but that we are providing a short-term crisis intervention meant to help people stabilize and rejoin us in our communities where we all work and play and live.

Thank you for the opportunity to testify before you today. If there are any questions I would be happy to respond.

PREPARED STATEMENT OF HON. RON WYDEN,
A U.S. SENATOR FROM OREGON

The Finance Committee is responsible for the programs—Medicare and Medicaid—that spend more on mental health than any others in America. That's why this committee, working in conjunction with others including HELP and Judiciary, must develop a fresh approach for protecting and caring for Americans with mental illness. The focus of that approach should be breaking health care, social service programs, and law enforcement out of their individual silos and bringing them together in a coordinated system that deploys their strengths to help people dealing with mental health issues.

The Wyden family knows a little bit about this subject. My brother struggled with schizophrenia for decades, and he had a lot of health care bills covered by Medicaid. In and out of halfway houses, confrontations with law enforcement officers, problems securing funds for services or treatments—it was certainly something that has confronted millions of families and demonstrates the need for a fresh approach to helping those with mental illnesses.

Instead, because of the lack of appropriate places to go, patients who deal with a lot of the same issues Jeff Wyden did have been boarded in emergency rooms. They've been in fights with police, sometimes deadly. Or they've wound up in prison, where more than half of all inmates suffer from mental health problems, and minorities are vastly overrepresented.

I'll be the first to say that mental health is not an issue that falls neatly under any one Senate committee's jurisdiction. A lot of different members with different

areas of expertise will have to pull the same end of the rope to make progress on this front. Senator Stabenow, right on this committee, is a champion of mental health. Senator Murray, the Democratic leader on the HELP Committee is also right at the forefront.

In my view, our efforts on mental health have to be concentrated on three priorities. First, there needs to be a sharp new focus on preventing mental illness. People need better care earlier on to keep illnesses from escalating. And furthermore, there are nearly 2 million low-income, uninsured Americans suffering from mental illness or addiction in States that have not expanded their Medicaid programs. That's 2 million Americans who, without treatment or help, are far more likely to fall into homelessness, far more likely to be incarcerated, far more likely to suffer from addiction, far more likely to commit suicide. The choice to expand Medicaid and give new hope to those 2 million individuals and their families, in my view, should be an easy one to make.

Second, services from health care to social work need to be better coordinated. It doesn't make much sense to tell a person struggling with an illness that they're on their own managing treatments, figuring out what specialists to see, scheduling appointments and handling medications. Even outside the doctor's office there are a lot of areas where people with mental illnesses often need help they're not getting today. Paying the bills. Making it to appointments. Maintaining a home. Taxpayer dollars need to reach deeper into our communities and improve coordination to help people who the system today overlooks.

Third, there needs to be a better link between mental health and law enforcement. In a lot of cases that's going to mean more training on what to do when responding to a person with mental illness. Too many people who should be in proper health care facilities are winding up in jail cells instead. In Portland, the Police Bureau has recently put a lot of work into building a team of specially-trained officers to handle these challenges safely, and it's paying big dividends in the early going. In my view, more agencies around the country ought to follow suit.

The big hurdle in all of this is funding. Each year, mental illness costs the U.S. \$450 billion, only a third of which is actually spent on medical care. At roughly \$75 billion combined, Medicare and Medicaid make up the biggest slice of the pie. Those are huge numbers, and a lot of the overall total goes to emergency room visits and jail time. In my judgement, if you can shift some of that funding to the three priorities I talked about—preventing mental illness, better coordinating care and services, and linking law enforcement with mental health—you'll see a lot more people successfully managing their mental illnesses and living healthier lives.

This is a tough challenge, and it's going to require a lot of bipartisan teamwork. But I'm optimistic that members will come together to make real progress, and I look forward to today's hearing.

COMMUNICATIONS

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On behalf of the more than 108,500 nationally certified PAs (physician assistants) represented by the American Academy of PAs (AAPA), we appreciate the Senate Finance Committee's interest in the state of the American mental healthcare system. While there are numerous policy challenges in this area, the most pressing may be the current shortage of mental healthcare providers. In light of the historical use of PAs to alleviate healthcare provider shortages, the increased number of PAs practicing in psychiatry, and the growing movement towards the integration of primary care and specialty care, AAPA believes that PAs should be—and are well-equipped to be—better utilized in the provision of mental healthcare.

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), an estimated 43.6 million Americans experienced some type of mental health issue in 2014. While the Affordable Care Act (ACA) attempted to make mental healthcare more accessible, many individuals who suffer from mental illnesses continue to go without treatment. For instance, SAMHSA's National Survey on Drug Use and Health found that in 2014, more than 15 million adults reported having a major depressive episode in the previous year. Yet, one third of those individuals did not seek the assistance of a mental healthcare provider. Although a variety of factors likely account for this disparity, the U.S. Department of Health and Human Services recently estimated 90 million people lack access to mental health and addiction medicine providers. Many of these individuals live in rural and medically underserved areas, where there are little or no options for public transportation and the nearest mental healthcare provider may be hours away. It is clear that more must be done to make treatment for mental illnesses more accessible for this population, as well as the public at large.

While early intervention for suspected mental illness is essential to ensuring positive mental and physical health outcomes for all patients, it is particularly important in the populations served by Medicare, Medicaid, and the Children's Health Insurance Program (CHIP), as they are typically less likely to have access to comprehensive and coordinated healthcare. SAMHSA has found that half of adults who have mental illnesses began showing symptoms by age 14. In 2014, more than 11% of youth between ages 12 and 17 had experienced a major depressive episode in the prior year. However, fewer than half of them received treatment or counseling. When combined with the everyday struggles of many families who rely on Medicaid or CHIP, it is easy to see why early intervention in mental healthcare issues within this population is essential.

At the same time, SAMHSA has estimated that 25% of older Americans have reported some kind of mental health problem, and 6.5 million seniors have been diagnosed with depression. As in younger populations, treatment for mental health issues in the Medicare population is necessary to ensure better healthcare outcomes across the board. Yet, an ongoing shortage of mental healthcare providers combined with continued struggles to better coordinate healthcare for all populations has meant that many individuals who are in the highest-need demographics are falling through the cracks. While there are many factors involved in creating a better mental healthcare system, AAPA believes better utilization of PAs in federal healthcare programs is essential to solving the overall access problem.

PA Education and Practice

PAs receive a broad education over approximately 27 months which consists of two parts. The didactic phase includes coursework in anatomy, physiology, biochemistry, pharmacology, physical diagnosis, behavioral sciences, and medical ethics. This is followed by the clinical phase, which includes rotations in medical and surgical disciplines such as family medicine, internal medicine, general surgery, pediatrics, obstetrics and gynecology, emergency medicine, and psychiatry. Due to these demanding rotation requirements, PA students will have completed at least 2,000 hours of supervised clinical practice in various settings and locations by graduation.

The majority of PA programs award a master's degree. PAs must pass the Physician Assistant National Certifying Examination and be licensed by a state in order to practice. The PA profession is the only medical profession that requires a practitioner to periodically take and pass a high-stakes comprehensive exam to remain certified, which PAs must do every 10 years. To maintain their certification, PAs must also complete 100 hours of continuing medical education (CME) every 2 years.

PAs practice and prescribe medication in all 50 states, the District of Columbia, and all U.S. territories with the exception of Puerto Rico. They manage the full scope of patient care, often handling patients with multiple comorbidities. In their normal course of work, PAs conduct physical exams, order and interpret tests, diagnose and treat illnesses, assist in surgery, and counsel on preventative healthcare. The rigorous education and clinical training of PAs enables them to be fully qualified and equipped to manage the treatment of patients who present with both physical and mental illnesses.

PAs and Mental Healthcare

PAs are recognized along with physicians and nurse practitioners under Medicare, ACA, and other federal healthcare programs as one of the three types of primary care providers. Overlap between primary care and mental healthcare has traditionally existed, particularly in settings which provide care for the medically underserved like hospitals, community health centers, rural health clinics, free clinics, and jails and prisons. This is largely due to the fact that many of these facilities' patients suffer from both physical and mental ailments and have little ability to obtain either primary or mental healthcare. In these situations, providers will often work to treat the whole patient. The interface between primary care and mental healthcare is becoming more common due to the growth of alternative payment models within Medicare, as well as efforts to better coordinate patient care at the federal level. As a result, primary care providers in all settings are beginning to offer mental health screenings, arrange "warm handoffs" to a mental health specialist, or work in tandem with a specialist via telemedicine or other means.

Many of the mental healthcare bills currently before Congress acknowledge the interface between primary healthcare and mental healthcare. Today, there are approximately 30,000 PAs practicing as primary care providers who are on the "front lines" of care. This means even if they do not specialize in mental healthcare, a significant number of PAs care for patients who reside in medically underserved areas and present with complex or comorbid conditions affecting both their physical and mental health. According to data collected by AAPA in 2015, 10% of all patients cared for by PAs suffer from depression. An additional 5% suffer from behavioral or other psychiatric conditions other than depression. PAs who practice in primary care are qualified to provide a full spectrum of healthcare services for these patients, including conducting patient histories and examinations, performing psychiatric evaluations and assessments, ordering and interpreting diagnostic tests, establishing and managing treatment plans, prescribing medications, and ordering referrals as appropriate, and they should be fully utilized as members of the care team.

At the same time, it is important to note that a growing number of PAs are receiving additional education to specialize in psychiatry. While Medicare recognizes these PAs as reimbursable mental healthcare providers, they are not always included in legislation as mental health professionals along with psychiatrists, psychologists, clinical social workers, and psychiatric nurse practitioners. PAs in psychiatry work in behavioral health facilities, jails and prisons, and psychiatric units of rural and public hospitals. These PAs are credentialed and privileged affiliate members of the medical staff who provide both initial and ongoing care to patients. Given the current shortage of providers in this field, it is critical that PAs in psychiatry be fully included as part of the mental healthcare team.

Recent Legislative and Administrative Actions

There have been some notable efforts in recent proposals by both Congress and the administration to better integrate PAs into mental healthcare. In March, the Senate Committee on Health, Education, Labor and Pensions (HELP) favorably reported S. 2680, the Mental Health Reform Act of 2016, a comprehensive bill directed at improving access to mental healthcare. AAPA supports this legislation because it acknowledges the role of primary care providers in assisting patients with mental illnesses, aims to increase coordination of care for patients needing primary and mental health care, and includes PAs in psychiatry among the specialty providers listed in the bill.

Additionally, the Health Resources and Services Administration (HRSA) recently acknowledged the role of PAs in mental healthcare and addiction medicine in its FY17 budget request by including them in the definition of “behavioral health workforce.” AAPA is pleased by this recognition, and we support HRSA’s efforts to further integrate primary care providers like PAs into mental healthcare by encouraging the use of screenings, referrals, and telemedicine to connect patients with mental health specialists when appropriate, all of which have been shown to improve patient outcomes and mitigate gaps in coverage caused by too few providers.

AAPA Legislative Recommendations

As the Committee works on solutions to the mental healthcare access problem, AAPA hopes you will consider the following recommendations:

- (1) **Affirmatively including PAs in mental healthcare legislation as members of the healthcare team.** This inclusion is important for all types of healthcare legislation, but it is especially important in mental healthcare given the critical level of provider shortages in this field. Moreover, as the Committee works on continuing to integrate primary care into mental healthcare, PAs should continue to be counted among primary care providers who may assist their patients in receiving mental healthcare when it is appropriate.
- (2) **Including “PAs in psychiatry” as mental healthcare providers.** Mental health legislation has historically included a number of specified mental healthcare providers, but left out PAs who specialize in psychiatry. There is a growing number of PAs who receive additional education to specialize in this field, and they work in behavioral healthcare centers and other high-need facilities. These PAs should be included in any definition of mental healthcare provider as a result of their qualifications and experience. S. 2680, the Mental Health Reform Act, is an example of how PAs can be included as part of the solution to mental healthcare provider shortages.

AAPA looks forward to working with the Committee as you move forward on these important issues. Please do not hesitate to have your staff contact Sandy Harding, AAPA Senior Director of Federal Advocacy, at 571-319-4338 or sharding@aapa.org should you have any questions.

AMERICAN ASSOCIATION FOR GERIATRIC PSYCHIATRY (AAGP)

The American Association for Geriatric Psychiatry (AAGP) appreciates this opportunity to comment on the status of Mental Health in America. AAGP is a professional membership organization dedicated to promoting the mental health and well being of older Americans and improving the care of those with late-life mental disorders. AAGP’s membership consists of geriatric psychiatrists as well as other health professionals who focus on the mental health problems faced by aging adults. Thus AAGP brings a unique perspective to the consideration of unmet mental health needs that plague our public healthcare services. We would like to take this opportunity to highlight the geriatric mental health workforce crisis that has crossed our nation’s doorstep.

The 2012 Institute of Medicine (IOM) report “The Mental Health and Substance Use Workforce for Older Adults: In Whose Hands?” clearly highlights that our current and future capacity to manage the complex medical needs of older adults with mental health or substance use conditions is grossly insufficient.

The aging of the baby boomer generation will result in an increase in the proportion of persons over 65 from 12.7 percent currently, to 20 percent in 2030, with the fastest growing segment of the population consisting of people age 85 and older. During

the same period, the number of older adults with major psychiatric illnesses will more than double, from an estimated 7 million to 15 million individuals, meeting or exceeding the number of consumers in discrete, younger age groups. In addition, 8 million Americans are estimated to have Alzheimer's disease by 2030, nearly all of who will have neuropsychiatric or behavioral symptoms that will require expertise in geriatric mental health from all clinical disciplines.

Virtually all health care providers need to be fully prepared to manage the common medical and mental health problems of old age. In addition, the number of geriatric health specialists, including mental health providers, needs to be increased to provide evidence-based care for those older adults with the most complex issues and to support and train the rest of the workforce as partners in collaborative care.

Unfortunately, workforce estimates for geriatric mental health do not look promising. By 2030, it is estimated there will be only 1,500 geriatric psychiatrists across the country, compared to the 4,000 to 5,000 needed based on estimates from the National Institute on Aging. Current rates of training geriatricians (~175 fellows per year) lag far behind what is needed (~1,200 fellows per year) to reach the goal of having 30,000 trained and providing care to our elders in 2030. Geriatric training is also rare among other common members of the geriatric mental health care team. For example, only 1% of Nurses, Pharmacists and Physician Assistants; ~2.6% of Advanced Practice Nurses; and ~4% of Social Workers have geriatric certification. Only 3% of Psychologists work primarily in elder care.

The 2012 IOM report recommended Congress appropriate funds that authorize training, scholarship, and loan forgiveness for individuals who work with or are preparing to work with older adults who have mental health or substance use conditions. We strongly encourage the Committee to ensure funding opportunities prioritize mental health training that focuses on the needs of vulnerable groups across the life span, including older adults.

Supporting training for geriatric mental health will improve access to evidence-based, high quality health care for our elders and will ensure recruitment and retention of top professionals into geriatric mental health practice. The well-being and dignity of our elders requires action now to ensure the workforce is prepared.

Submitted by:

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STATEMENT SUBMITTED BY JOHN BORONOW, M.D.

I am a practicing psychiatrist who has lived in Maryland for 35 years. I specialize in the treatment of schizophrenia and other "severe and persistent" mental disorders. I worked at Sheppard Pratt back in the days of the IMD exclusion, when there were no Medicaid adults. Later came the waiver, and since then, the State of Maryland has supported Medicaid patients until last autumn. I have treated Medicaid inpatients for nearly 20 years, in addition to the Medicaid outpatients I have always treated since opening my practice. I also am an Associate Clinical Professor of Psychiatry at the University of Maryland and teach residents and medical students daily about public policy toward this patient population.

The IMD exclusion is simply another example of an historical anachronism that has lingered on well beyond its original intended life span. It was created in an era before deinstitutionalization, when asylums and private hospitals ran a parallel existence and when there were virtually no psychiatric inpatient units in general medical hospitals. Medicaid was invented right alongside the Community Mental Health Act in the mid 1960s to transform the delivery of behavioral healthcare. The intent of the IMD exclusion was to prevent state hospitals from gobbling up new Federal dollars to maintain an otherwise dying model of care, and to prevent rich private hospitals from accessing funds for institutions that frankly did not need them.

When Sheppard Pratt first treated our Medicaid adults in the late 1990s, we had already started to build a continuum of care including day hospitals, crisis residential care, and residential rehabilitation programs in suburban apartment complexes.

For us, access to Medicaid enabled us to treat thousands of severely and persistently ill mental patients who were in Maryland emergency rooms. What we brought to the table was expertise: a small 20 bed general psychiatric unit has to treat all comers, and it is impossible to be expert at all things. But a large IMD with great depth is able to do more than just do crisis intervention, and can actually successfully treat complex cases which would otherwise be overwhelming to small programs.

It is time to end the IMD exclusion. Deinstitutionalization is done, and it was done so poorly that in fact we have transinstitutionalized patients from state hospitals to the criminal justice system. We need now to finish the work: **to deinstitutionalize the laws** (which limit commitment to bricks and mortar facilities instead of to a system of care in the community) and **to update the funding rules** like the IMD exclusion, which exclude patients from centers of excellence that can actually solve difficult clinical challenges instead of just kicking them down the road in the endless cycle of "revolving door" hospitalizations. IMDs are now part of the solution, they have changed with the times, and the funding should now finally follow suit.

STATEMENT SUBMITTED BY EVELYN BURTON

Thank you for allowing this opportunity for public input on how the Finance Committee can improve the Mental Health System.

Limited Medicaid funds need to be targeted more to treatment of those with Serious Mental Illness who are at high risk for homelessness, incarceration, victimization, and suicides. This will save both lives and money.

I urge the repeal of the discriminatory Medicaid Institutions for Mental Diseases (IMD) exclusion which denies medically necessary appropriate psychiatric hospital care to adults with severe mental illness. For no other conditions are Medicaid services excluded in certain medical institutions.

If you decide to limit the number of days authorized in an IMD, I urge you to allow at least 30 consecutive days, regardless to the month. The proposed rule of allowing 15 days per month in an IMD is unworkable from a medical prospective. If the intent is to allow 30 days to a patient who enters an IMD on the 15th of the month, why should others who require a 30 day stay and enter an IMD on the first of the month be kicked out after 15 days? Will patients be encouraged to wait in the ER until the 15th of the month or told by their doctor to wait 15 days and increase the risk of criminalization, or suicide? Will the IMD try to discharge them to a general hospital for one day and then readmit them? This type of rule encourages high risk game playing with the lives of the seriously mentally ill.

The IMD exclusion policy of Medicaid is a barrier to hospital treatment and stabilization, and also reduces the incentive for expansion of hospital beds.

I have personally seen individuals, with schizophrenia and bipolar disorder, in many families, that cycle continually between Community Hospital, homelessness, and jail, because they are never adequately stabilized in the very short hospitalizations provided by most general hospitals. Those lucky enough to have private insurance that pays for a longer stay in an IMD have been better stabilized and are less likely to be quickly rehospitalized or incarcerated.

I even know of one family that withdrew their family member from Medicaid so that they could pay privately for a 6 week stay at an IMD, to achieve stabilization and stop the frequent hospitalizations. It was very successful. That individual has not been hospitalized now for over 10 years, thus saving Medicaid millions of dollars. Those on Medicaid should have the same opportunity for stabilization.

The IMD exclusion is a disincentive for expansion of critically needed hospital beds and has contributed to a shortage of hospital beds nationwide. This results in Emergency Room boarding and driving vast numbers of those with serious mental illness into the criminal justice system. In Maryland over 90% of the state hospital beds are now taken by forensic patients, and there is no availability for non-forensic patients. Also those in my County jail may wait for weeks for a hospital bed, denying their right to proper medical treatment.

The IMD Waiver Demonstration Program for hospitals has shown reduced costs with the use of IMDs. It is past time to act on those results, stop discrimination against those with serious mental illness, and save lives.

The IMD exclusion for outpatient residential services is also highly detrimental for those with serious mental illness and needs to be repealed entirely or at a bare minimum, allow for much larger facilities than 16 beds. Some with serious mental illness do NOT recover to the point of being able to live independently or with part time supervision. However they can live in the community with intensive supervision and this is much less costly and more humane than frequent hospitalizations or incarcerations. Allowing Medicaid payment for outpatient residential treatment in facilities over 16 beds would allow for the economic expansion of critically needed residential treatment beds. Larger facilities do not mean that the residents would be “institutionalized.” Just like those living in Senior Communities, or Assisted Living Facilities, those in a residential outpatient treatment program can be engaged in community activities.

I also urge repeal of the discriminatory Medicare lifetime limit on psychiatric hospital days. There is no lifetime hospital limit for any other illness. It denies critical treatment to the most vulnerable of our elderly population and contributes to the very high suicide rate in the elderly.

Thank you for your consideration.

Sincerely,

Evelyn Burton, consumer and family advocate.

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The Clinical Social Work Association (CSWA) would like to thank you for the opportunity to comment on this hearing. CSWA serves as the Voice of Clinical Social Work, representing the 240,000 licensed clinical social workers in the country, the largest single group of independent mental health clinicians.

It is well documented that untreated or undertreated behavioral health problems tend to become more severe, and often exacerbate other medical conditions as well. That coverage for mental health conditions continues to be less broad than what is offered for medical conditions turns logic on its head, ultimately increasing overall health care costs.

When the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) passed, licensed clinical social workers and their patients were hopeful that the ways in which mental health disorders were under-treated and under covered by insurers would be resolved. Sadly, what we have seen instead are numerous coverage restrictions on mental health treatment, imposed by insurers by means of limits on “acceptable” diagnoses and/or treatment methods, frequency of sessions, length of treatment, and patient access to out of-network clinicians.

The lack of precise definitions for parity standards has been a major failure of MHPAEA. This problem can be seen clearly in area of “non-quantitative” treatment limitations, where insurers restrict treatment authorization on the basis of “treatment progress” when in fact there is no absolute way to determine treatment progress except when the patient has fewer hospitalizations, when the patient and clinician agree the patient has less emotional suffering, has *more significant and continuing impact* on improved mental health (Levy, et al., “The Efficacy of Psychotherapy,” *Psychodynamic Psychiatry*, 42(3) 377-422, 2014). Additionally, the cross-discipline surveys done by *Consumer Reports* (1995, 2004 and 2008) show that psychotherapy provided by psychologists and licensed clinical social workers have widely positive results in treating depression, anxiety, trauma-based disorders, and even psychotic disorders.

Where in-patient mental health treatment is concerned, we understand that budgetary consequences must be addressed—and decisions based—on a realistic assessment of the costs of providing adequate mental health and physical health care. However, we would be remiss if we failed to point out two glaring gaps in mental health treatment for chronic and severe conditions:

- The limitation to 190 days of inpatient treatment for psychiatric reasons. There is no such limitation on medical conditions, and clearly this violates MHPAEA.

- The lack of *any* coverage for Medicaid beneficiaries who need inpatient mental health care in what are called Institutes for Mental Disease. The IMD restrictions are unfair, and cause harm to those who need inpatient care for mental health conditions.

We ask that the Task Force add these two coverage gaps—limitations which have a devastating effect on individuals coping with chronic mental health conditions (as well as their families and communities)—to the range of issues under consideration.

On a more general level, CSWA would like to note the following concerns:

- As clinicians, we have long been aware of the inadequate coverage of chronic mental health conditions on the inpatient and outpatient level. We are concerned, as well, that the critically important integration of medical/surgical care and mental health/substance use care continues to be elusive.
- Another area of CSWA concern is the general lack of attention to diversity that we believe has been a major factor in the successful delivery of health care and mental health treatment. Cultural competence is not just basic to our clinical social work approach to treatment, but fundamental to any health or mental health treatment. Understanding of the patient's ethnicity, gender, sexual orientation, economic levels, race, age, religion, and other areas of personal identity is essential.
- Finally, Accountable Care Organizations, with their goal of creating delivery systems that would share profit and loss with providers, have great potential for controlling overall healthcare costs in America. However, mental health treatment is, at present, seriously underfunded, and we fear that ACOs will not be viable as health care delivery systems for treatment of chronic mental health conditions without a significant increase in funding. The fiscal targets that are to be met must be realistic or this form of funding mental health treatment is likely to fail.

There is no question that mental health treatment is cost effective in the long run, often preventing other health problems and/or more severe mental health problems. We applaud the work of the Task Force in reviewing the range of issues hindering parity in mental health and substance use treatment, and look forward to your final report.

Thank you for the opportunity to make these comments.

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Statement Submitted for the Record by Janet Hays

Dear Chairman Hatch and respected members of the committee,

I am the wife of someone with a serious mental illness (SMI) as well as an advocate for alternatives to incarceration, homelessness and death for mentally ill people in my community.

As the director of Healing Minds NOLA, an organization I began last year, I hear from many residents who struggle with the broken mental healthcare system. The most tragic stories always involve the inability of the caregiver to ensure that their loved ones with serious mental illness are getting—and taking—medications necessary to manage their illness. Funding should be directed to evidence-based programs and services that provide support to that group of people.

- **Assisted Outpatient Treatment (AOT)** is legal in almost every State in the nation and avoids hospitalization. It's a compassionate and creative approach to getting care to more difficult cases where a person's disease has become more powerful than the person. AOT ensures that a person follows their treatment plan in order that they can make competent decisions for themselves. When a person is medication compliant, it reduces conflicts that can escalate in families and communities and helps to prevent incarceration for unacceptable behavior. By keeping sick people out of corrections institutions, they preserve their civil rights and right to self-determination and stay out of the downward spiral that leads to further deterioration and further costs to society. AOT should be funded and scaled up.
- **More inpatient beds are needed so eliminate the IMD Exclusion.** The case of my friend Eleanor Chapman's daughter demonstrates this need. Post-Katrina, New Orleans went from 128 to virtually zero long-term inpatient public psychiatric beds after the State shuttered Charity Hospital. Due to bed shortages—and HIPAA rules—Eleanor was unable to get her daughter Chelsea Thornton the care and treatment she needed after having her involuntarily committed at least three times. Consequently, Chelsea—who had a long history of mental illness—took the lives of her two children one evening in a tragic psychotic episode. To this day, Chelsea remains at the newly named “Orleans Justice Center” (it's a jail) while she awaits trial.
- **Loosening HIPAA restrictions** would have a major impact on helping a mentally ill person be medication compliant by permitting caregivers to know about a patient's treatment plan. It would not require funding outside of what it costs to educate healthcare providers about legislative changes.
- **Group homes should also be part of the recovery equation.** Personality disorders and intellectual disabilities and/or developmental disorders make it challenging to live independently. Some need daily help. When done properly and with proper oversight, group homes can provide loving and caring environments that many people cannot find elsewhere.
- **Stop funding stigma and use savings to treat SMI.** A 2011 survey by the SAMHSA Center for Behavioral Health Statistics and Quality found stigma (mentioned by 7% of respondents) was low on the list of why people with mental illness do not receive care, far behind cost (50%). Stigma also came behind could handle problem without treatment, did not know where to go, lack of time, belief that treatment wouldn't help, anosognosia (did not feel need for treatment), and lack of insurance as the reason people don't get care.

In a survey of Californians who had difficulty getting care for mental illness, three times as many (63%) said cost was a reason, versus that they were afraid or embarrassed to ask for help (21%). A recent study in *Psychological Medicine*, “What is the impact of mental health-related stigma on help-seeking” found stigma was only the fourth highest reason people didn't seek care.

A 2011 study, “Barriers to Mental Health Treatment” found “low perceived need for treatment” was the primary barrier to treatment with everything else—including stigma—far behind.

<http://www.centerforhealthjournalism.org/2014/10/17/new-study-stigma-not-major-barrier-treatment-people-mental-illness>

We need to deal with 3 demographics. The population of people at the epicenter of the crisis meaning those who are warehoused in jails and prisons, those who are near incarceration, homelessness or death and those people at the earliest stages of disease. Right now, our funding priorities are backward. While there are more robust services for mental wellness issues, there is little for people with mental illness. We are now feeling the impacts of our neglect. Families know that if they can keep their loved ones medication compliant, mental wellness will follow but it doesn't work the other way around.

LETTER SUBMITTED BY NANCY JONES

Dirksen Senate Office Bldg.
Washington, DC 20510-6200

Hello!

I write this as a parent, married 55 years. We were thrown into the mental illness system, not by choice but for love and concern for our seriously mentally ill son, now 48. My husband and I feel like we failed or rather the broken mental illness non-care snake pit has deserted us and most horribly our son and heartbroken two sons he has been unable to care for.

In every instance of this painful journey of ours he has slipped through the cracks from every entity out there that our taxes pay for to bring needed medical care, hospitalization, and after-care for this lifelong brain disease.

The saddest part of this nightmare is this could be a workable solution to rendering the proper care and yet I blame the behavior health system at hand for putting our son out homeless, hospitals and those in the field of psychiatric care for outright malpractice for not treating our son psychotic, delusional. Screaming at voices only he hears, so pathetically unable to make decisions for himself or care for his personal hygiene. He was immediately told he had rights to refuse medical care, labeled a consumer, not a sick patient and when after all loss of insight to his illness he was thrown to the streets.

As parents we were kept from helping him receive medical care. I was told on many occasions by professionals that, "he has a right to be crazy if he chooses." This HIPAA law keeps family from being involved being scolded that he isn't bad enough yet, he needs to be an imminent danger to self/others to hospitalize. Police told me since after his ranting and raving at imaginary Satan, for days, since he hadn't injured either of us, they couldn't take him to a hospital. They left two disabled senior parents to deal with him. I told them I'd let them know when he tries to kill one of us believing we were the devil.

He has been incarcerated, without meds or psychiatric care, now in a jail program some 2,000 miles from our home. The state psychiatric hospital here in Illinois that would have treated him without Medicaid while waiting the 2 years for SSI was closed by our state to save money. Saving money, no way, losing a productive life and sky high taxes going into the legal, courts, jails and prison system. Treating these very ill human beings is far more cost effective. Instead of closing hospitals for the streets, we need more hospital beds with trained medical personnel in the psychiatric field, not jail cells.

Our son doesn't have a behavior problem, he suffers a brain disease; he should be put into an AOT program, ordered by a judge, not dropped from a useless program because he didn't follow rules he signed in a contract. Many uninformed preach, it's all about stigma. They're wrong, it's all about non-treatment.

Treatment before tragedy is what we need, not yoga and art classes that are wonderful for relaxation and enjoyment but do nothing in the needed medical care for the sickest of the sick in this country right now.

Parents need to be able to take part in their adult child's commitment and care, not even notified their loved one is in a psychiatric hospital until after being released after the 72 hour hold and being homeless because they have rights.

As our son is so ill he has a human right to medical care to be a productive person again, hopefully. What some in power to make changes in this broken system of ours don't realize is that some don't get well, some untreated don't even live.

We need a workable bill to help families in mental illness crisis, not a watered down one like those representing their own personal interests here to keep their federal and state jobs are pushing for. They callously don't want to believe our son has a medical disease and has a right to treatment. H.R. 2646 offers all this to bring on reform.

Thank you for the opportunity,

Nancy J. Jones.

STATEMENT SUBMITTED BY MARILYN MARTIN

1. There are three *Federal laws* that need to change, the first two within your purview: (1) the IMD exclusion, which excludes Medicaid patients from psychiatric facilities that have more than 16 beds, such as Sheppard Pratt in Maryland. (2) The lifetime Medicare hospitalization limit is discriminatory. There are no other limitations on physical illnesses. My son's schizophrenia is a neurobiological dis-

ease. (3) HIPAA laws that prevent caretaker families like mine from knowing basic information that would be helpful in keeping our loved ones in care. For example, I should have been notified that my son had just fired his clinic provider a couple of weeks prior to his recent assault on my husband. Since I had no HIPAA release (because my son had lost insight to his illness), I was not notified. I later learned that he had even run out of the pills that were no longer working, but they did help him sleep. Lack of sleep is a trigger for psychosis.

2. *Professional Shortages:* We need more neuro-psychiatrists, and we need for them to be better compensated—because treated SMI (neurological brain diseases) can be extremely challenging, and often dangerous. We also need more incentives for clinical licensed social workers to treat the SMI rather than the “worried well.” My son was able to find one therapist at his clinic who was effective for a few months before she left the clinic to return to school. She was the only therapist he was willing to see during the entire 8 years since his first psychosis. These community clinics have high turnover and difficulty in attracting highly qualified professional staff.
3. *Beds.* Maryland needs more beds for psychiatric disorders. This is especially crucial for patients such as my son, who has had to wait for a bed on several occasions.
4. Many disorders and diseases currently referred to as mental illnesses are actually neurological disorders, according to NIH. My 32-year-old son has schizophrenia. Although I believe that early treatment provides better outcomes, I do not believe that the word, “prevention” has meaning for the families of those with serious neurological brain diseases. (I believe in higher funding for brain research would help with that.)
5. My son was recently placed on a new injectable antipsychotic that I believe is effective. His SSDI and SSI payments are so low that he would not be able to afford any increase in paying for them should Medicare reduce reimbursement. He does not need another excuse for opting out of his monthly injections. He’s already done that in the past. To save money, perhaps injectables could be administered by a nurse rather than a doctor?
6. Limited funds need to be focused on the more serious brain illnesses. One reason treatment is expensive is that many of our **state-level “behavioral health” treatment laws actually promote disability.** For example, my son recently spiraled into a serious psychosis after decompensating on a medication that had stopped working—he had developed a tolerance to it. Every time a person relapses like this, the likelihood of his returning to his previous level of functioning is lowered because he’s lost grey matter. Many states, such as mine, will only allow us to get our loved ones who lack insight back into appropriate treatment when they become “dangerous.” **States should be rewarded for having more reasonable commitment standards.** Hence, we had to wait until my son became psychotic and assaulted my spouse. He is now awaiting trial. **States should be rewarded for having an Assisted Outpatient Treatment statute.** This way, those few with a history of decompensating repeatedly could be kept out of the criminal justice system before it is too late. If my son is fortunate enough to receive long-term in-patient care rather than jail time, he should be able to be stabilized enough to learn how to manage his chronic illness, thereby staying appropriately medicated. An additional problem is that my state’s “disabilities law center” emphasizes getting out of the hospital within 72 hours rather than focusing on keeping these patients in treatment. Promoting very short stays places limits on stabilizing on new medications. This is counterproductive for a patient with a serious illness like schizophrenia, who would need at least 2–3 weeks to stabilize on a new antipsychotic medication. My son has had at least 16 hospitalizations within the past 8 years, all very short. Mr. Cornyn seems to have some understanding of the issues we have with noncompliance. Thank you, Mr. Cornyn.

Thank you for your interest in mental health for which we have a good system. I had no trouble finding good trauma therapy for PTSD after my son’s recent assault. However, for serious mental illness (brain disorders) **there is no reliable system,** and family care givers are worn out, stressed out, often fearful, and left out from useful information from providers due to HIPAA. Please take action soon to help us save lives, keep our loved ones out of prisons, or trying to survive as homeless.

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We thank Senator Hatch for his opening statement which identified the single most important core issue:

As we talk about solutions, we need to note that the distinction between mental health, mental illness, and severe mental illness is crucial, because each group requires different clinical and policy prescriptions. For example, the current system, proportionally speaking, provides far more support for mental health than severe mental illness. We need to review these priorities and find an equitable solution to ensure that all needs are being met.

One-hundred percent of Americans can have their mental health improved. Twenty percent have a mental health diagnosis. These are often mild and remit on own. But only 4% have a serious mental illness like those suffered by the brother of Senator Wyden (schizophrenia) and father of Senator Stabenow (bipolar disorder).¹ Those serious mental illnesses are not preventable or identifiable before the symptoms become manifest which is usually in late teens and twenties. So elementary school age interventions are not likely to bend the curve.

It is seriously mentally ill adults, not children or the worried-well who are most likely to become homeless, arrested, incarcerated, suicidal, and dangerous to themselves or others. Congress should reject pressure to move funds to younger groups, groups without mental illness, and programs that promise “prevention.” Congress should keep its eye on getting treatment to adults known to have serious mental illness. Congress has tended to balkanize funding. It funds programs for children, seniors, veterans, pregnant women, LGBT, high school students, college students, African Americans, Native Americans, immigrants and other special sub-populations. The mental health industry has convinced funders that bad grades, single parent households, unhappy marriages, underemployment, unemployment, sexual confusion, criminal involvement, and other issues are “risk-factors” and diverted funding for them. For example, there are 5,500 suicides of individuals under age 24 and Congress allocates \$55 million to preventing those. But there are 37,500 suicides in those over 24 and Congress only allocates \$2 million to them.² Under pressure from the mental health industry, Congress is spending where suicide is not, rather than where it is. Creating these multiple priority populations, leaves less for the elephant in the room: getting treatment to adults known to have serious mental illness, what should be the core population. But there are rarely programs targeted to them.

Congress should ensure that both *existing funds and incremental funds* are spent on interventions that meet these three criteria: have independent evidence; improve a meaningful outcome like reducing homelessness, arrest, incarceration, homelessness and hospitalization; and reduce violence in people with serious mental illness.

Programs to eliminate

Virtually none of the programs funded by SAMHSA meet those three criteria. We have documented SAMHSA’s failure at <http://mentalillnesspolicy.org/samhsa.html>. SAMHSA funds antipsychiatry and pseudo-science. It declares non-evidence based practices to be evidence based, encourages states to use mental health block grant funds Congress appropriated for mental illness on people without mental illness, refuses to focus on the seriously ill, refuses to focus on improving meaningful outcomes, and wastes money. There is little support for SAMHSA other than from those who receive funds from it. Their own employees rated is the 319th worst federal agency and its former top doc just wrote an op-ed explaining that she left SAMHSA largely for the reasons I just explained. Congress should take funds that go to CMHS unit of SAMHSA that don’t help the seriously ill move them to programs that do help. Any CMHS programs that are worthy of continuing can be

¹ Substance Abuse and Mental Health Services Administration (SAMHSA). “NSDUH 2013 Report: Substance Use and Mental Health Estimates from the 2013 National Survey on Drug Use and Health: Overview of Findings.” Rockville, MD, September 2014. Available at <http://store.samhsa.gov/shin/content/NSDUH14-0904/NSDUH14-0904.pdf>.

² Testimony of SAMHSA Acting Director Kana Enomoto at House Appropriation Hearing: Substance Abuse and Mental Health Services Administration Budget, March 2, 2016. Available at <https://www.youtube.com/watch?v=Mke5HKRusMI>.

moved to NIMH, IOM, CDC, DOJ and other entities that will use them more appropriately.

PAIMI. PAIMI has moved off its original purpose of preventing abuse of the institutionalized mentally ill to preventing treatment of the seriously ill. There is not a mental health director who has tried to improve services for the seriously ill who has not found a PAIMI advocate on the other side. PAIMI responsibilities can be moved to the CRIPA unit within DOJ which is largely duplicative.

Programs to support

Programs that have independent evidence they improve a meaningful outcome in people with serious mental illness and should be expanded include:

- Assisted Outpatient Treatment (AOT). We no longer have to make a binary choice between the total removal of rights via incarceration and involuntary commitment and unfettered freedom in the community. By allowing judges to order a small group of the most seriously ill *who already have a history of violence, incarceration, or homelessness* to accept mandated and monitored treatment in the community, it reduces homelessness, arrest, incarceration and violence in the 70% range. This is all the more outstanding because AOT is only for the most seriously ill who have not been helped by voluntary services. By replacing expensive inpatient hospitalization and incarceration with less expensive outpatient treatment, it cuts the cost to taxpayers in half. A fact sheet is enclosed.
- Access to hospitals. Eliminate the IMO Exclusion. As a result of the IMO Exclusion, states lock the front door and open the back causing incarceration of the seriously ill. There are 10 times as many mentally ill incarcerated. Because IMO amelioration can be expensive (because CBO does not score offsetting savings) we suggest starting with providing IMD relief to non-forensic state hospital beds. There are very few of those left, so the cost would not be excessive. Congress could also raise the number of beds from 16 to say, 24 which would allow IMO funds to go to the seriously ill without dramatically increasing costs. Another approach would be to allow IMO relief for X number of hospital days. CMMI issued regs that allow 15 days of hospital care per month, but that only affects capitated patients. Congress should mandate it for non-capitated ACA enrollees. A *Washington Post* op-ed is enclosed.
- Group Homes. Some of the most seriously mentally ill do not do well in the independent supported housing currently being promoted. They are now well enough to manage a household and drive-by case management is not enough. They need on-site 24/7 support of the kind that can be found in group homes.
- Clubhouse Model programs. Congress should establish (or direct CMMI to establish) a bundled Medicaid rate for clubhouse programs. Clubhouses, like New York's Fountain House, are unique in that they serve the most seriously ill. However, the unique model, whereby several patients can be served at once does not neatly fit the Medicaid model.

Finally, we urge Congress to give those of us who provide housing and case management services to seriously mentally ill out of love, the same access to information paid providers receive. HIPAA and FERPA prevent the families of people from seriously ill from knowing the diagnosis, treatment, medications and pending appointments. We are therefore powerless to see prescriptions are filled and appointments kept.

As Michael Biasotti, former President of the NYS Chiefs of Police told a House Energy and Commerce Committee, "We have two mental health systems. The traditional mental health system helps those well enough to volunteer for services. Those who are not well enough to volunteer are turned over to criminal justice. The mental health system seems unwilling to accept responsibility for this more symptomatic group." The main task of the Finance Committee should be to reorient services back to the seriously ill. Thank you. Attached are fact sheets on some of these issues.

Sincerely,

D.J. Jaffe
Executive Director

How the Federal Government Can Help the Most Seriously Mentally Ill

Focus on the 4% with serious mental illness,
not just the 18% with poor mental health.

Background: Some of the most seriously mentally ill (SMI), unlike people with less severe “mental health issues” hallucinate, are delusional, psychotic, and can’t think straight (cognitive impairment). Some need periodic hospital care, a small group will never recover, and some as a result of cognitive impairments and anosognosia, are unwilling or unable to stay in treatment even when available and offered to them. Most mentally ill are not violent, but when the seriously mentally ill go untreated, they are at higher risk of violence.

Pretending these issues don’t exist is causing massive homelessness and incarceration of the seriously ill. Federal legislation tends to focus on higher functioning, and/or less important issues. Following are specific policies that would help persons with the most serious mental illnesses. Prepared by Mental Illness Policy Org. <http://mentalillnesspolicy.org>, May 14, 2015.

Policy	Which seriously mentally ill does it help?	How it helps
Fund Assisted Outpatient Treatment	AOT helps a very small but important group of the most seriously ill who because of inability or unwillingness to stay in treatment <i>already</i> accumulated <i>multiple</i> incidents of homelessness, arrest, violence, incarceration, or hospitalization <i>after</i> being offered voluntary services that were made available to them. This small group, because of their known history, is the most likely to again become hospitalized, homeless, arrested, incarcerated and possibly violent. Note: AOT is <i>not</i> an alternative to community services. AOT is a way to help the seriously ill access community services. http://mentalillnesspolicy.org/national-studies/aotworks.pdf	<i>Extensive replicated research</i> shows AOT helps SMI stay in existing community treatment and avoid expensive and rights-depriving inpatient commitment and incarceration. <ul style="list-style-type: none"> • 74% fewer participants experienced homelessness • 77% fewer experienced psychiatric hospitalization • 83% fewer experienced arrest • 87% fewer experienced incarceration • 81% said AOT helped them get and stay well • Reduces hospitalization/incarceration costs 50%.
Repeal Institutes for Mental Disease (IMD) Reform	IMO repeal would help a small group of the most seriously mentally ill who even if there were perfect community services cannot survive safely in the community because medications and other treatments do not work for them or they require the much more intensive support than the higher functioning. The IMO Exclusion prevents reimbursement for this care and is federally sanctioned discrimination against the seriously ill. It affects no other group and should be eliminated. http://mentalillnesspolicy.org/imd/ind-nasmhp.html	Hospitals reduce incarceration America’s mentally ill held in— Prison 2001: 600,000 Mental Hospitals 2001: less than 50,000
Remove “HIPAA Handcuffs”	HIPAA reform would help seriously mentally ill who have families willing to provide housing, case management, and financial support to them. But HIPAA prevents families from being told the diagnosis, what medications and rehabilitation is needed, and therefore cannot see prescriptions are filled and transportation arranged. (http://mentalillnesspolicy.org/national-studies/HIPAA_handcuffs.pdf)	By giving Moms and Dads who provide care out of love the same information that paid providers receive parents can prevent their relatives from becoming too psychotic to keep at home and from becoming a government responsibility.

Policy	Which seriously mentally ill does it help?	How it helps
Eliminate or Reform SAMHSA	<i>SAMHSA elimination</i> would help the most seriously ill who need help based on the scientific “medical model” rather than the SAMHSA-invented “recovery model” which requires patients to self-direct their own care, something some of the most seriously ill cannot do. (http://mentalillnesspolicy.org/samhsa.html)	SAMHSA elimination would free states of the SAMHSA-instituted obligation to use Mental Health Block Grants for people without mental illness and curtail SAMHSA funded consumer trade association from lobbying against hospitals and other treatments that help the most seriously ill. It would stop SAMHSA funding antipsychiatry, the certification of programs that do not have independent evidence, etc. This would save taxpayers money while helping SM get care. The few useful programs can be transferred to CDC, NIMH, IOM, etc.
Require PAIMI to focus on abuse and neglect	Persons with serious mental illness who have been subjected to “abuse or neglect.” (http://mentalillnesspolicy.org/myths/paimifails2011samhsaevaluation.html)	PAIMI primarily focuses on “freeing” the non-seriously ill from care, rather than helping the seriously ill access it. Threat of suits prevents states and hospitals from helping the seriously ill. Having PAIMI focus on abuse and neglect would reduce both.

[The Washington Post, December 30, 1999]

FEDERAL NEGLECT OF THE MENTALLY ILL

By D.J. Jaffe and Mary T. Zdanowicz

The recently released Surgeon General's Report on Mental Health is the equivalent of describing the maiden voyage of the Titanic without mentioning the iceberg. While the report criticizes private insurance companies for failing to provide “parity” in their coverage of mental illnesses, it is totally silent on the failure to provide parity in Medicaid, the federal government's insurance program.

For the most severely mentally ill, private insurance is essentially meaningless. Because of their illnesses, most are indigent, and private insurance is a luxury they cannot afford and are not in a position to obtain through employment.

Many of these individuals do have insurance through Medicaid a federal insurance program that covers their care, except for a single exception—inpatient care in psychiatric hospitals. The federal government's Institution for Mental Diseases (IMD) exclusion prohibits Medicaid from reimbursing for most individuals who need care in a psychiatric hospital. If you have a disease in your heart, liver or any other organ and need treatment in a hospital, Medicaid contributes. But if you have a disease in your brain and need care in a psychiatric hospital, Medicaid does not.

As a result of this federally sanctioned discrimination, state psychiatric hospitals are locking the front door and opening the back, making it increasingly difficult for the most severely ill to get inpatient treatment. They are discharging patients sicker and quicker in a headlong dash to make them Medicaid eligible by ending their inpatient residency.

There were about 470,000 individuals receiving inpatient psychiatric care in state hospitals when the Medicaid program started in 1965, compared with fewer than 60,000 today. Hospital closures have actually accelerated in recent years. Forty state hospitals shut their doors between 1990 and 1997, nearly three times as many as during the entire period from 1970 to 1990, and many more closings are planned.

Of the 3.5 million Americans with schizophrenia and manic-depression, 40 percent (1.4 million) are not being treated. Medicaid's denial of coverage results in homelessness, incarceration, victimization and even death for many people who are so ill they are unable to care for themselves. By the Justice Department's own statistics, there

are currently about 283,800 mentally ill people locked up in the nation's jails and prisons.

The Los Angeles County Jail and New York's Riker's Island are currently the two largest "treatment facilities" for the mentally ill in the country. Another 150,000 to 200,000 mentally ill are homeless, and 28 percent get at least some of their meals from garbage cans. More than 10 percent will die from suicide. Others will commit acts of violence against family, friends, and total strangers.

Not only does federal discrimination hurt the mentally ill, it affects the standard of living for everyone else, too. Many parks and public libraries, once enjoyed by all, are now rendered nearly unusable to the general community by the visions of lost, psychotic souls who need inpatient care but are locked out by the discrimination embedded in Medicaid law. Seemingly random acts of violence committed by individuals with a history of mental illness are frequently reported on the evening news. No amount of preaching by the Surgeon General against "stigma" will overcome the acts of a Russell Weston, a Ted Kaczynski or an Andrew Goldstein, all persons with untreated schizophrenia.

The federal government must accept its share of criticism for a policy that discriminates against individuals solely on a diagnosis of mental illness. We must steer clear of the iceberg that sank our state psychiatric hospital system and eliminate the Medicaid IMD exclusion.

D.J. Jaffe is Executive Director of Mental Illness Policy Org. Mary Zdanowicz is (former) Executive Director of the Treatment Advocacy Center.

All Studies Show Assisted Outpatient Treatment (AOT) Reduces Homelessness

AOT Study/Source	Findings
Substance Abuse and Mental Health-Services Administration (SAMHSA) National Registry of Evidence based Practices and Programs (NREPP) 2015.	"Although numerous AOT programs currently operate across the United States, it is clear that the intervention is vastly under-utilized."
Agency for Healthcare Research and Quality (AHRQ) U.S. Department of Health and Human Services Management Strategies To Reduce Psychiatric Re-admissions May 2015.	AOT "programs improve adherence with outpatient treatment and have been shown to lead to significantly fewer emergency commitments, hospital admissions, and hospital days as well as a reduction in arrests and violent behavior."
Department of Justice "Crime solutions: assisted outpatient treatment" http://www.crimesolutions.gov/ 2012.	Assisted outpatient treatment is an effective crime prevention program.
Bruce Link, Matthew Epperson, Brian Perron, Dorothy Castille, Lawrence Yang. "Arrest outcomes associated with outpatient commitment in New York State." <i>Psychiatric Services</i> 62, no. 5 (2011): 504-508.	"For those who received AOT, the odds of any arrest were 2.66 times greater ($p < .01$) and the odds of arrest for a violent offense 8.61 times greater ($p < .05$) before AOT than they were in the period during and shortly after AOT. The group never receiving AOT had nearly double the odds (1.91, $p < .05$) of arrest compared with the AOT group in the period during and shortly after assignment."
Allison Gilbert, Lorna Mower, Richard Van Dorn, Jeffrey Swanson, Christine Wilder, Pamela Clark Robbins, Karli Keator, Henry Steadman, Marvin Swartz. "Reductions in arrest under assisted outpatient treatment in New York," <i>Psychiatric Services</i> 61, no. 10 (2010): 996-999.	"The odds of arrest for participants currently receiving AOT were nearly two-thirds lower (OR=.39, $p < .01$) than for individuals who had not yet initiated AOT or signed a voluntary service agreement."

All Studies Show Assisted Outpatient Treatment (AOT) Reduces Homelessness—Continued

AOT Study/Source	Findings
<p>Marvin Swartz, Christine Wilder, Jeffrey Swanson, Richard Van Dorn, Pamela Clark Robbins, Henry Steadman, Lorna Moser, Allison Gilbert, John Monahan. "Assessing outcomes for consumers in New York's assisted outpatient treatment program." <i>Psychiatric Services</i> 61, no. 10 (2010): 976–981.</p>	<p>"The likelihood of psychiatric hospital admission was significantly reduced by approximately 25% during the initial six-month court order . . . and by over one-third during a subsequent six-month renewal of the order. . . . Similar significant reductions in days of hospitalization were evident during initial court orders and subsequent renewals. . . . Improvements were also evident in receipt of psychotropic medications and intensive case management services. Analysis of data from case manager reports showed similar reductions in hospital admissions and improved engagement improved services."</p>
<p>Jo Phelan, Marilyn Sinkewicz, Dorothy Castille, Steven Huz, Bruce Link. "Effectiveness and outcomes of assisted outpatient treatment in New York State." <i>Psychiatric Services</i> 61, no. 2 (2010): 137–143.</p>	<p>Kendra's Law has lowered risk of violent behaviors, reduced thoughts about suicide, and enhanced capacity to function despite problems with mental illness. Patients given mandatory outpatient treatment—who were more violent to begin with—were nevertheless four times less likely than members of the control group to perpetrate serious violence after undergoing treatment. Patients who underwent mandatory treatment reported higher social functioning and slightly less stigma, rebutting claims that mandatory outpatient care is a threat to self-esteem.</p>
<p>New York State Office of Mental Health, Kendra's Law: Final Report on the Status of Assisted Outpatient Treatment. Report to Legislature, Albany: New York State, 2005, 60.</p>	<p>Danger and violence reduced</p> <ul style="list-style-type: none"> • 55% fewer recipients engaged in suicide attempts or physical harm to self • 47% fewer physically harmed others • 46% fewer damaged or destroyed property • 43% fewer threatened physical harm to others • Overall, the average decrease in harmful behaviors was 44% <p>Consumer outcomes improved</p> <ul style="list-style-type: none"> • 74% fewer participants experienced homelessness • 77% fewer experienced psychiatric hospitalization • 56% reduction in length of hospitalization • 83% fewer experienced arrest • 87% fewer experienced incarceration • 49% fewer abused alcohol • 48% fewer abused drugs <p>Consumer participation and medication compliance improved</p> <ul style="list-style-type: none"> • The number of individuals exhibiting good adherence to meds increased 51% • The number of individuals exhibiting good service engagement increased 103% <p>Consumer perceptions were positive</p> <ul style="list-style-type: none"> • 75% reported that AOT helped them gain control over their lives • 81% said AOT helped them get and stay well • 90% said AOT made them more likely to keep appointments and take meds • 87% of participants said they were confident in their case manager's ability • 88% said they and their case manager agreed on what was important to work on

All Studies Show Assisted Outpatient Treatment (AOT) Reduces Homelessness—Continued

AOT Study/Source	Findings
<p>Jeffrey Swanson, Richard Van Dorn, Marvin Swartz, Pamela Clark Robbins, Henry Steadman, Thomas McGuire, John Monahan. "The cost of assisted outpatient treatment: can it save states money?" <i>American Journal of Psychiatry</i> 170 (2013): 1423–1432</p>	<p>In New York City net costs declined 50% in the first year after assisted outpatient treatment began and an additional 13% in the second year. In non-NYC counties, costs declined 62% in the first year and an additional 27% in the second year. This was in spite of the fact that psychotropic drug costs increased during the first year after initiation of assisted outpatient treatment, by 40% and 44% in the city and five-county samples, respectively. The increased community-based mental health costs were more than offset by the reduction in inpatient and incarceration costs. Cost declines associated with assisted outpatient treatment were about twice as large as those for voluntary services.</p>
<p>Marvin Swartz, Christine Wilder, Jeffrey Swanson, Richard Van Dorn, Pamela Clark Robbins, Henry Steadman, Lorna Moser, Allison Gilbert, John Monahan. "Assessing outcomes for consumers in New York's assisted outpatient treatment program." <i>Psychiatric Services</i> 61, no. 10 (2010): 976–981.</p> <p>Marvin Swartz, Jeffrey Swanson, Henry Steadman, Pamela Clark Robbins, John Monahan. "New York State assisted outpatient treatment program evaluation." Duke University School of Medicine, Durham, NC, 2009</p>	<p>"We find that New York State's AOT Program improves a range of important outcomes for its recipients, apparently without feared negative consequences to recipients."</p> <ul style="list-style-type: none"> • Racial neutrality: "We find no evidence that the AOT Program is disproportionately selecting African Americans for court orders, nor is there evidence of a disproportionate effect on other minority populations. Our interviews with key stakeholders across the state corroborate these findings." • AOT improves the likelihood that providers will serve seriously mentally ill: "It is also important to recognize that the AOT order exerts a critical effect on service providers stimulating their efforts to prioritize care for AOT recipients." • AOT improves service engagement: "After 12 months or more on AOT, service engagement increased such that AOT recipients were judged to be more engaged than voluntary patients. This suggests that after 12 months or more, when combined with intensive services, AOT increases service engagement compared to voluntary treatment alone." • Consumers Approve: "Despite being under a court order to participate in treatment, current AOT recipients feel neither more positive nor more negative about their treatment experiences than comparable individuals who are not under AOT."
<p>Michael Heggarty. "The Nevada County Laura's Law experience." Behavioral Health Department, Nevada County, Nevada County, CA, November 15, 2011</p>	<p>In Nevada County, CA, AOT ("Laura's Law") decreased the number of Psychiatric Hospital Days 46.7%, the number of Incarceration Days 65.1%, the number of Homeless Days 61.9%, and the number of Emergency Interventions 44.1%. Laura's Law implementation saved \$1.81–\$2.52 for every dollar spent, and receiving services under Laura's Law caused a "reduction in actual hospital costs of \$213,300" and a "reduction in actual incarceration costs of \$75,600."</p>
<p>Marvin Southard. "Assisted Outpatient Treatment Program Outcomes Report" Department of Mental Health, Los Angeles County, Los Angeles, CA, February 24, 2011.</p>	<p>In Los Angeles, CA, the AOT pilot program reduced incarceration 78%, hospitalization 86%, hospitalization after discharge from the program 77%, and cut taxpayer costs 40%.</p>
<p>Virginia Hiday, and Teresa Scheid-Cook. "The North Carolina experience with outpatient commitment: a critical appraisal." <i>International Journal of Law and Psychiatry</i> 10, no. 3 (1987): 215–232.</p>	<p>In North Carolina, AOT reduced the percentage of persons refusing medications to 30%, compared to 66% of patients not under AOT.</p>

All Studies Show Assisted Outpatient Treatment (AOT) Reduces Homelessness—Continued

AOT Study/Source	Findings
Mark Munetz, Thomas Grande, Jeffrey Kleist, Gregory Peterson. "The effectiveness of outpatient civil commitment." <i>Psychiatric Services</i> 47, no. 11 (1996) 1251–1253.	In Ohio, AOT increased attendance at outpatient psychiatric appointments from 5.7 to 13.0 per year. It increased attendance at day treatment sessions from 23 to 60 per year. "During the first 12 months of outpatient commitment, patients experienced significant reductions in visits to the psychiatric emergency service, hospital admissions, and lengths of stay compared with the 12 months before commitment."
Robert Van Putten, Jose Santiago, Michael Berren "Involuntary outpatient commitment in Arizona: a retrospective study." <i>Hospital and Community Psychiatry</i> 39, no. 9 (1988): 953–958.	In Arizona, "71% [of AOT patients] . . . voluntarily maintained treatment contacts six months after their orders expired" compared with "almost no patients" who were not court-ordered to outpatient treatment.
Barbara Rohland. "The role of outpatient commitment in the management of persons with schizophrenia." Iowa Consortium for Mental Health Services, Training and Research, 1998.	In Iowa "it appears as though outpatient commitment promotes treatment compliance in about 80% of patients. . . . After commitment is terminated, about ¾ of that group remain in treatment on a voluntary basis."
Treatment Advocacy Center. "Success of AOT in New Jersey 'Beyond Wildest Dreams.'" Treatment Advocacy Center. September 2, 2014.	In New Jersey, Kim Veith, director of clinical services at Ocean Mental Health Services, noted the AOT pilot program performed "beyond wildest dreams." AOT reduced hospitalizations, shortened inpatient stays, reduced crime and incarceration, stabilized housing, and reduced homelessness. Of clients who were homeless, 20% are now in supportive housing, 40% are in boarding homes, and 20% are living successfully with family members.
Virginia Hiday, Marvin Swartz, Jeffrey Swanson, Randy Borum, H. Ryan Wagner. "Impact of outpatient commitment on victimization of people with severe mental illness." <i>American Journal of Psychiatry</i> 159, no. 8 (2002): 1403–1411.	"Subjects who were ordered to outpatient commitment were less likely to be criminally victimized than those who were released without outpatient commitment."
Jeffrey Swanson, Marvin Swartz, Richard Van Dorn, John Monahan, Thomas McGuire, Henry Steadman, Pamela Clark Robbins. "Racial disparities in involuntary outpatient commitment: are they real?" <i>Health Affairs</i> 28, no. 3 (2009): 816–826.	"We found no evidence of racial bias. Defining the target population as public-system clients with multiple hospitalizations, the rate of application to white and black clients approaches parity."

Some of the problems at the Substance Abuse and Mental Health Services Administration (SAMHSA)

SUMMARY: Congress directed SAMHSA "to target . . . mental health services to the people most in need" (Conference Committee May 19, 1992) (ADAMHA Reorganization Act 1992). Priority populations were defined as adults with a serious mental illness and children with a serious emotional disturbance (U.S. Congress n.d.). SAMHSA refuses to focus on the most seriously ill and refuses to focus on the most consequential issues like reducing violence, incarceration, hospitalization, and homelessness.

In a 2015 survey of federal employees, SAMHSA was ranked 317th worst government place to work out of 320 government agencies (Partnership for Public Service 2015). Employees cited ineffective leadership as biggest problem. A 2015 General Accountability Office audit found SAMHSA fails to coordinate the nation's mental health policies, most of its mental health programs don't serve the seriously ill, and most programs that do serve the seriously ill go unevaluated (GAO 2015). Former SAMHSA Administrator Pam Hyde told Congress on a scale of one to ten, "SAMHSA is a ten."

SAMHSA's Strategic Plan ignores serious mental illness

SAMHSA's 2011–2014 strategic plan directed its mental health resources toward "creating a high-quality, self-directed, satisfying life integrated in the community for all Americans" (emphasis added) (SAMHSA 2011). A top SAMHSA official told *Time* magazine: "The behavioral health of the entire population is a priority for SAMHSA" (emphasis added) (Sanburn 2013). Of SAMHSA's six 2015–2018 "strategic initia-

tives” only one mentions serious mental illness and that is limited to preventing it. Serious mental illness cannot be prevented (SAMHSA 2014).³

SAMHSA replaced the scientific “medical model” with a SAMHSA-invented “recovery model”

Instead of medical evidence, SAMHSA relies on popularity contests, convening meetings of “stakeholders” and letting them vote on priorities. SAMHSA stacks their meetings with high-functioning consumers and mental “health” organizations and excludes police, sheriffs, and others concerned about serious mental illness and issues like hospitalization, arrest, violence, homelessness, and incarceration. That’s what SAMHSA did when it wanted to replace the proven medical model of treating serious mental illness with a politically correct “Recovery Model.”

SAMHSA’s Recovery Model includes “10 Guiding Principles of Recovery.” The most important is that “self-determination and self-direction are the foundations for recovery.” That makes the recovery model dangerous to some as it makes no allowance for the fact that there are individuals with severe mental illness who cannot self-direct their care. “Under the ‘recovery model,’ John Hinckley was defining his own life goal—the attention of Jodie Foster—when he shot President Reagan” (Torrey and Jaffe 2013).

SAMHSA claims it knows how to prevent serious mental illness and diverts funds to it

As former NIMH Director Dr. Thomas Insel noted, we can’t prevent serious mental illness because “we do not know the cause [and] we lack a biomarker that is 100% accurate for diagnosis” (Insel 2014). But prevention is SAMHSA’s number one strategic initiative: “Prevention Works” is part of its motto, and a “National Prevention Week” is held annually (SAMHSA 2011). SAMHSA-funded advocates parade the word “prevention” in front of legislators—along with spreadsheets showing the alleged savings—in order to increase their own funding. SAMHSA often quotes a 1994 Institute of Medicine (IOM) report (IOM 1994). But the report said, “To date, the definitions [of prevention] have been so broad and flexible that almost everything has been labeled prevention at one time or another. *Thus the nation is spending billions of dollars on programs whose effectiveness is not known.*” SAMHSA uses the 2009 update to the 1994 IOM report to justify diverting funds to prevention (IOM 2009). But that report focuses only on youth and specifically excludes “some rare but often severe disorders; for example, schizophrenia and bipolar disorders.”

SAMHSA diverts millions to stigma in spite of their own research showing it is not a major barrier to care

SAMHSA teaches the public and Congress that stigma is an important reason people do not receive care and provides massive funding to this tangential issue. But a 2011 survey by the SAMHSA Center for Behavioral Health Statistics and Quality found stigma (mentioned by 7% of respondents) was low on the list of why people with mental illness do not receive care, far behind cost (50%). Stigma also came behind could handle problem without treatment, did not know where to go for services, lack of time, belief that treatment wouldn’t help, anosognosia (did not feel need for treatment), and lack of insurance. SAMHSA does virtually nothing on these other issues, and focuses its resources on stigma.

SAMHSA knows peer support does not improve meaningful outcomes in people with serious mental illness but diverts funds to it

SAMHSA funds peer supporters, peer travel, peer conferences, peer webinars, and peer support organizations and coerces states to use mental health block grant funds for peer support. (Mental Illness Policy Org. 2013) The Center for Mental Health Services (CMHS) is headed by a peer and focuses on little else. Yet, SAMHSA’s own research shows: “The literature [on peer support] that does exist tends to be descriptive and lacks experimental rigor” (SAMHSA–BRSS 2012). SAMHSA “peer-run respite centers” only accept those well enough to volunteer.

SAMHSA refuses to certify programs that help the seriously mentally ill and certifies programs that don’t

SAMHSA encourages states to spend mental health block grants on programs listed in their National Registry of Evidence-based Programs and Practices. NREPP is a sham, little more than an assemblage of privately developed workshops, training sessions, and courses. Little of what’s in it are actual treatments, serve the seriously

³ Of SAMHSA’s eight 2011–2014 “strategic initiatives,” only one involved getting treatment to adults with serious mental illness, and that was limited to veterans (SAMHSA 2011).

ill, or improve meaningful outcomes. The “evidence” SAMHSA uses to evaluate the programs often comes straight from those who invent, sell, and profit from the listed programs.

- Mental Health First Aid (MHFA) ostensibly teaches people to identify the symptoms of mental illness in others and connect them to help. The three studies SAMHSA relied on to certify it were all done by the owners/vendors of the program (SAMHSA–NREPP 2012). Their research shows only that those who give and receive the training like it; they do not show that it improves outcomes for people with mental illness. There are studies that found no benefit for people with mental illness, but they were not submitted by the vendors to SAMHSA and therefore were ignored by SAMHSA (Mental Illness Policy Org. 2013).
- Four of the five “studies” SAMHSA used to certify Triple-P Positive Parenting, a program that teaches parents of misbehaving children how to be better parents were conducted by the vendor of the program, Prof. Matt Sanders (SAMHSA–NREPP 2014). Numerous independent studies show it doesn’t work (Coyne and Kwakkenbos 2013) (Wilson, et al. 2012).
- The two studies used to certify the Wellness Recovery Action Plan (WRAP), which teaches people to develop a wellness plan were conducted at least partially by Mary Ellen Copeland, the vendor of the program. Like MHFA, WRAP is not proven to benefit the seriously mentally ill who receive it (Mental Illness Policy Org. 2013). SAMHSA recently gave Ms. Copeland a large grant.

SAMHSA certifies programs as being “effective” even when they don’t improve meaningful outcomes, such as reducing violence, arrest, incarceration, suicide, homelessness, and hospitalization. Many programs SAMHSA certifies as effective only improve soft outcomes, like “satisfaction,” “feeling of wellness,” “empowerment,” “hopefulness,” and “resiliency.”

SAMHSA refuses to evaluate programs that actually help improve meaningful outcomes in people with serious mental illness including Assertive Community Treatment (ACT) Teams, Intensive Case Managers (ICM), Crisis Intervention Teams (CIT), Assisted Outpatient Treatment (AOT) and Mental Health Courts.

SAMHSA prevents states from using block grant money to help people with serious mental illness

The legislation establishing mental health block grants requires they be used for “adults with serious mental illness” and “children with serious emotional disturbance” and narrowly defines those terms (CMHS 1993). But the SAMHSA instructions and application process ignores that direction and encourages states to use the funds for people without mental illness. (Mental Illness Policy Org. 2013):

“The focus is about everyone, not just those with an illness or disease, but the whole population” (emphasis added) (SAMHSA 2012, SAMHSA 2014).

SAMHSA invented a new mental illness: trauma

SAMHSA invented a mental illness it calls “trauma.” No reputable psychiatrist considers trauma an illness. Post-traumatic stress disorder (PTSD) is an illness, and even that can run from mild to severe. SAMHSA never exactly defined trauma, but declared “Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual’s functioning and physical, social, emotional, or spiritual well-being” (SAMHSA 2012). These definitions can therefore include anyone who got divorced, found their spouse was cheating, knows someone who died, was in a storm, or had any event they “experienced as . . . emotionally harmful” if it affected their “spiritual well-being.”

SAMHSA created a National Center for Trauma Informed Care and has awarded major trauma grants to organizations like the National Association of State Mental Health Program Directors (NASMHPD) (SAMHSA 2006). That is money going to preventing trauma rather than treating serious mental illness.

SAMHSA funds antipsychiatry and antipsychiatrists

SAMHSA is responsible for distributing funds that Congress intended to support programs of “Regional and National Significance” (OMB 2013). Too much of it goes directly to antipsychiatry and other organizations that oppose treatment. It is hard to find an antipsychiatry organization that does not receive financial or PR support from SAMHSA. SAMHSA’s *Mental Illness Awareness Week Guide* suggests that schools invite the MindFreedom, the Icarus Project, and the National Coalition for

Mental Health Recovery (NCMHR) into classrooms to teach children about mental illness (SAMHSA October 2010). MindFreedom based in Oregon believes “mental illnesses are not brain diseases” (MindFreedom 2008). The Icarus Project believes “these experiences—commonly diagnosed and labeled as psychiatric conditions—are mad gifts needing cultivation and care, rather than diseases or disorders” (Icarus Project 2014). The National Coalition for Mental Health Recovery (NCMHR), the umbrella group for SAMHSA funded peer-run non-profits believes “psychiatric labeling is a pseudoscientific practice of limited value in helping people recover” (NCMHR 2012).

SAMHSA’s support of these individuals and organizations has enabled them to prevent states from improving services for the seriously ill by keeping hospitals open, implementing AOT, using ECT, housing seriously mentally ill in congregate settings, hiring professionals in lieu of peers, and has thereby made incarceration of many seriously mentally ill people more likely.

SAMHSA wastes money intended to help people with serious mental illness

SAMHSA uses its budget to publish and distribute children’s books, such as *Play Day in the Park* for 3- and 4-year-olds; *Look What I Can Do!* for 5- and 6-year-olds; coloring books, such as *Wally Bear and Friends*; and my favorite, *The Lion and the Mouse* sing-along (SAMHSA 2011). SAMHSA has scores of free publications covering non-mental illness including “What a Difference a Friend Makes” and publications on oil spill response, hurricane recovery, American Indian and Alaska native culture, peer pressure, social marketing, employment services, and health promotion. But SAMHSA has only a single publication on schizophrenia, and it is out of stock (Torrey and Jaffe 2013). SAMHSA commissioned a \$22,500 painting of Native Americans by a Native American artist, “to help raise awareness about the roles of families and the community in mental and substance abuse disorder prevention.” It sits in SAMHSA’s headquarters.⁴ SAMHSA spent \$200,000 to put on a party at Paramount Studios in Hollywood (Coburn 2013).

SAMHSA recently led a “National Wellness Week” to encourage “visiting a farmers’ market, taking a class on nutritional cooking, ‘drinking a veggie or fruit smoothie,’ reading poetry, making a collage, taking a walk, joining a song circle, taking a class on how to make sacred drums, . . . and join[ing] the Line Dance for wellness . . .” because ‘dancing is a great stress reliever and also provides social interaction’ (Torrey, The Ridiculous “National Wellness” Week 2014).

SAMHSA downplays and minimizes violence thereby stymieing efforts to reduce it

Violence is not associated with poor mental health but is associated with serious mental illness *that is allowed to go untreated*. SAMHSA refuses to admit to or address that.

SAMHSA promotes “prevention” knowing serious mental illness cannot be prevented

NIMH had similar problems of mission-creep that were solved when its previous director was replaced by Dr. Thomas Insel. The problem at SAMHSA is not lack of money, it’s having too much.

NATIONAL ALLIANCE TO END HOMELESSNESS

May 12, 2016

The Honorable Orrin G. Hatch
Chairman
Finance Committee
U.S. Senate
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Finance Committee
U.S. Senate
Washington, DC 20510

Chairman Hatch, Ranking Member Wyden, and members of the committee:

On behalf of the National Alliance to End Homelessness, we appreciate the opportunity to submit a statement for the record. The Alliance is a nonprofit, non-partisan organization committed to preventing and ending homelessness in the

⁴Until recently, SAMHSA also put on an annual in-house musical to celebrate World AIDS Day.

United States. By improving policy, building capacity, and educating opinion leaders, the Alliance has become a leading voice on this issue.

Evidence indicates that mental illness is a known risk factor for homelessness, and data clearly shows that mental illness disproportionately impacts homeless people. In 2014, almost 20 percent of the adults in the United States experienced any mental illness (AMI), and 4.1 percent had serious mental illness (SMI).¹ In contrast, 18.1 percent of people who experienced homelessness on a single night in 2014 had SMI.² Research has shown that integrated treatment which incorporates housing components provides better outcomes than usual care for people who are homeless.³

Therefore, we encourage the Committee to ensure that housing supports are included in any legislation as a necessary component of mental health treatment.

The following pending Senate legislation has been endorsed by the Alliance and provides for comprehensive services to meet the needs of people with mental illness who are experiencing homelessness:

- S. 2525, Expand Excellence in Mental Health Act: This bill authorizes the expansion of a 2014 demonstration of Certified Community Behavioral Health Centers (CCBHs). CCBHs ensure availability and accessibility of behavioral health services to vulnerable populations including those experiencing homelessness. CCBHs are encouraged to partner with homeless services providers or local continuums of care.
- S. 2680, Mental Health Reform Act of 2016: This bill strengthens mental health and substance abuse care and improve access to treatment. The Act requires state plans for comprehensive community-based health systems that include employment and housing services as well as other supportive services that are essential to ending homelessness. The Act also authorizes the use of funds to provide employment and housing supports.
- S. 524, Comprehensive Addiction and Recovery Act of 2016: This bill encourages housing to be coordinated with medication assisted treatments and behavioral health interventions for the treatment of opioid use disorders.

We hope to continue to work with this Committee to effectively treat mental illness and end homelessness, two national concerns that can be solved.

Sincerely,

Nan Roman
President and CEO

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April 28, 2016

The Honorable Orrin G. Hatch
Chairman
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510-6200

The Honorable Ron Wyden
Ranking Member
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510-6200

Dear Chairman Hatch and Ranking Member Wyden,

¹ Center for Behavioral Health Statistics and Quality (2015). Behavioral health trends in the United States: Results from the 2014 National Survey on Drug Use and Health (HHS Publication No. SMA 15-4927, NSDUH Series H-50). Retrieved from <http://www.samhsa.gov/data/>.

² https://www.hudexchange.info/resource/reportmanagement/published/CoC_PopSub_NatITe rrDC_2015.pdf.

³ Hwang, S., Tolomiczenko, G., Kouyoumdjian, F., and Garner, R. Interventions to improve the health of the homeless: a systematic review. *Am. J. Prev. Med.* 2005 Nov; 29(4):311-9.

On behalf of the National Alliance on Mental Illness (NAMI) and the National Association of Psychiatric Health Systems (NAPHS), we want to thank you for convening today's important hearing on "Mental Health in America: Where Are We Now?" We appreciate your focus on this vital issue.

Mental illnesses are the leading cause of disability and contribute to premature death, yet millions of Americans face discrimination when they need the help the most.

Medicaid is the single largest funding source for people living with mental illnesses, but a little-known provision in the law called the Medicaid Institutions for Mental Disease (IMD) Exclusion prevents adult Medicaid beneficiaries (ages 21–64) from accessing short-term, acute care in psychiatric hospitals.

The IMD Exclusion is discriminatory and for years has disadvantaged Medicaid beneficiaries living with serious mental illness. People are not getting the psychiatric hospital treatment they need, putting families and communities at risk. In the end, this is—pure and simple—a fairness issue. A Medicaid insurance card covers hospital treatment for all other medical conditions, but adults with mental illnesses cannot use their Medicaid insurance card for inpatient psychiatric care in a psychiatric hospital. No other disorder limits hospital choice in the way the IMD Exclusion does.

The Medicaid IMD Exclusion was part of the original Medicaid program in 1965 and was intended to ensure that the states (rather than the federal government) would be primarily responsible for the costs associated with inpatient psychiatric treatments. Long ago, in 1965, the vast majority of inpatient psychiatric care was provided in state mental hospitals and was primarily long-term, custodial care.

Of course, this is no longer the case. Today the vast majority of inpatient psychiatric hospital care is provided in the community in general hospital psychiatric units or freestanding, non-governmental psychiatric hospitals. Inpatient stays today for psychiatric illnesses are measured in days (on average less than 10 days), not in weeks or months.

Over the past two decades, there has been a major decline in the number of inpatient psychiatric beds throughout the country. This has resulted in an increased number of individuals ending up in emergency rooms where they stay for days (and sometimes weeks) before being able to get the crisis inpatient hospital stabilization treatment they so desperately need. A Government Accountability Office (GAO–09–347) report on hospital emergency departments concluded difficulties in transferring, admitting, or discharging psychiatric patients from emergency departments were factors contributing to emergency department overcrowding.

Community psychiatric hospitals could help relieve these backups if Congress made a targeted, exception to the IMD Exclusion for short-term, acute, psychiatric hospital treatment.

A question that is sometimes asked by policymakers and advocates is whether modifying the IMD Exclusion would lead to more institutionalization. The answer is that this is about people who are in major crisis and need hospitalization to keep them safe. Hospital stays in the community are short and focus on crisis stabilization, helping people continue their recovery in the community.

Some also ask, why not invest in community care instead of hospitals? This is not a question of "either/or." What is needed is a partnership in care. Hospitals are handling the most acute needs of that person (so they don't hurt themselves or others), and then hospitals work with their community partners to handle the next step. This is not dissimilar to someone who has a heart attack, who needs hospitalization to stabilize the situation and then moves onto a rehabilitation facility and then home with continuing supports. What is needed are reforms to the IMD Exclusion that expand access to acute inpatient care and quality measures that ensure connection to outpatient services after a short-term stay in a hospital. In addition, reforms to the IMD Exclusion should also address the disparity that currently excludes non-elderly adults with mental illness from community services funded under state waiver programs.

There are many approaches that have been identified to address the growing crisis of the shortage of inpatient psychiatric beds in this country. And there is growing bipartisan support in both the House and Senate to address the discriminatory and outmoded IMD Exclusion. There are comprehensive mental health reforms bills that have been introduced in the Senate and House, including the Mental Health Reform Act of 2016 introduced by Senators Bill Cassidy (R–LA) and Chris Murphy (D–CT)

which includes a targeted, exception to the IMD Exclusion to cover short-term, psychiatric hospital treatment.

Making a change to the IMD Exclusion is the right thing to do and will result in more timely access to life-saving inpatient treatment, reduced emergency backlogs, and a more cost-effective system.

We look forward to continuing to work with the committee to address this unfair and discriminatory policy, so that individuals living with mental illnesses can get the right care at the right time.

Sincerely,

Mary Giliberti, J.D.
Chief Executive Officer
National Alliance on Mental Illness (NAMI)

Mark Covall
President and CEO
National Association of Psychiatric Health Systems (NAPHS)

NATIONAL ASSOCIATION OF ANOREXIA NERVOSA AND ASSOCIATED DISORDERS (ANAD)
750 E. Diehl Road #127
Naperville, IL 60563

May 9, 2016

Senator Orrin G. Hatch
Chairman
U.S. Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

Senator Ron Wyden
Ranking Member
U.S. Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Hatch and Ranking Member Wyden:

Thank you for your commitment to improving our nation's mental health care system and for holding a hearing on April 28 to examine the roles that the Medicare and Medicaid programs play in addressing the needs of those with behavioral and mental health issues.

I write today on behalf of the National Association of Anorexia Nervosa and Associated Disorders (ANAD) and the patients we represent. Formed in 1976, ANAD is a non-profit association dedicated to the prevention and alleviation of eating disorders. We focus particularly on anorexia nervosa, bulimia nervosa and binge eating disorder, and we advocate for the development of healthy attitudes, bodies, and behaviors. ANAD promotes eating disorder awareness, prevention and recovery through supporting, educating, and connecting individuals, families and professionals.

Eating disorders are common mental illnesses and can kill. Every 62 minutes at least one person dies as a direct result from an eating disorder.

Anorexia is the third most common chronic illness among adolescents, and it has the highest mortality rate among *all* mental illnesses—between 10 and 20 percent of those who have the illness will die. Further, eating disorders cause medical complications including cardiac arrhythmia, cardiac arrest, brain damage, infertility and osteoporosis, in addition to other mental health conditions such as anxiety and depression.

Appropriate and timely diagnosis and treatment of an eating disorder is absolutely crucial in achieving positive health outcomes for the patient. Eating disorders can be successfully and fully treated but, unfortunately, only about one third of people with an eating disorder ever receive treatment.

Such treatment can often be lengthy—from months to years—but early intervention and proper treatment improve a patient's prognosis and chances of a full recovery. As such, ANAD advocates for the reduction of barriers and obstacles to insurance benefits and discriminatory medical management of those struggling with all eating disorders.

ANAD applauds the steps taken by Congress over the past decade to improve mental health care access and coverage—including mental health parity and related provisions in the Affordable Care Act (ACA). That said, more can and must be done in order to ensure that those suffering from eating disorders are not denied access to the care they need. In particular, steps must be taken to ensure that low-income individuals and families are able to receive coverage for eating disorders treatments under the Medicaid program.

Improvements to Medicaid coverage are imperative to ensuring that all patients have access to the eating disorder treatments that are needed to save their lives. In addition, physicians and counselors in the Medicaid program need the training that is imperative to successfully treating an eating disorder. Skilled clinicians with specific eating disorder expertise are essential for treatment, yet eating disorder specialists are still not available in some communities.

Specifically, ANAD strongly supports the Anna Westin Act (S. 1865), a bipartisan eating disorders bill that was introduced in July 2015 and referred to the Senate Committee on Health, Education, Labor, and Pensions (HELP). The bill is named after Anna Westin, a young Minnesotan who committed suicide as a direct result of her battle with anorexia in February 2000. Since that time, Anna's family has turned their grief into something positive by founding the Anna Westin Foundation and working to ensure that tragedies such as Anna's are prevented in the future.

The Anna Westin Act is a comprehensive eating disorders bill that focuses on both training and treatment measures, and it will help those affected with eating disorders get the treatment they need and deserve. Using current funds from the Department of Health and Human Services (HHS), the bill would help train health professionals, school personnel and the public on how to identify eating disorders and how to help prevent the development of behaviors that may lead to eating disorders. In addition, S. 1865 would clarify the mental health parity law to include residential treatment service coverage—affording the same protections as other illnesses.

The bipartisan Anna Westin Act has 12 cosponsors in the Senate, and its House counterpart (H.R. 2515) has 82 cosponsors. Importantly, key provisions of the bill were incorporated into the comprehensive mental health bill that was approved by the HELP Committee on March 16.

ANAD applauds this bipartisan effort and sincerely hopes that as you work with your HELP Committee colleagues to bring a full scale mental health reform effort to the Senate floor, you will support these provisions that are so important to those suffering from eating disorders, as well as their families and loved ones.

Again, thank you for the opportunity to share our thoughts on the need to improve our nation's mental health care system—particularly from the perspective of treating and preventing eating disorders.

Should you have questions or need additional information, do not hesitate to contact me directly at 630-577-1333 or laura.zinger@anad.org. Additionally, do not hesitate to contact ANAD's Washington Counsel at McDermott, Will, and Emery: Karen Sealander, Partner, at 202-756-8024 or ksealander@mwe.com; and Erica Stocker, Public Policy Advisor, at 202-756-8334 or estocker@mwe.com.

Sincerely,

Laura Zinger
Executive Director

STATEMENT SUBMITTED BY CHRISTINA NUÑEZ DAW, MPH, PH.D.

While this hearing's agenda includes information about positive efforts to integrate mental and physical health care delivery, address suicide risk, and meet adolescent mental health needs, it is disappointing that a long-standing barrier to psychiatric and substance addiction treatment is not being discussed—the exclusion of federal Medicaid funding for adult (age 21–64) treatment in IMDs (Institutions for Mental Disease) with over 15 beds. I urge the Committee to support the elimination of the IMD exclusion by ensuring that this provision is restored to S. 2680, the mental health reform bill.

Rather than increasing health care costs, the elimination of the IMD exclusion would *save resources* now spent in hospital emergency rooms, jails, and prisons, and

care for homeless mentally ill patients. We are wasting precious resources in these non-treatment settings because our nation is seriously short on inpatient mental health beds and treatment. Unfortunately, the Congressional Budget Office issued a cost estimate for this provision (eliminating the IMD exclusion) that likely overstates the expenditures needed, while ignoring resulting cost-saving in non-federal expenditures.

- CBO estimated the cost of allowing federal funds for IMDs at \$40–\$60 billion over 10 years.
- Yet, in the multi-year Medicaid Emergency Psychiatric Demonstration (MEPD), the cost of providing community inpatient mental health treatment for individuals in acute mental illness crisis, averaged \$6,724 per admission; the 26 month demonstration covered over 11,500 admissions for just under \$78 million (state and federal dollars) in 12 states.¹
- Even assuming an admission volume of 25 times the number of admissions in the 12-state MEPD demonstration, the total estimated federal expenditure would likely be less than the CBO's estimate.
- Moreover, if we provided treatment instead of jailing mentally ill persons, we would save the \$30,000–\$50,000 per mentally inmate currently incarcerated.

Hospital emergency room directors have long raised the concerns that the lack of inpatient beds has forced them to board seriously mentally ill persons in crisis, taking up beds in ERs and in wards while delaying admissions of persons with other critical illnesses. Moreover, the IMD exclusion is in clear conflict with mental health parity laws, by discriminating against patients based on type of illness and associated treatment.

The Senate mental health reform bill, S. 2680, lacks this crucial component that was contained in S. 1945 and is still addressed in the current House mental health reform bill. I urge the Finance Committee to restore this provision in S. 2680 and ensure it is preserved in the House-Senate legislative reconciliation process.

STATEMENT SUBMITTED BY PATRICIA RANNEY

URGENT NEED OF PARITY: MENTAL ILLNESS = MEDICAL ILLNESS:

As a concerned parent, grandmother, citizen and constituent, I urge REPEAL OF DISCRIMINATORY IMD EXCLUSIONS. Medicaid denies payment to psychiatric hospitals over 16 beds, for patients from 21 to 65 years old . . . but doesn't do same with medical hospitals.

Also REPEAL LIFETIME LIMIT OF MEDICARE FOR TREATMENT OF MENTAL ILLNESS. . . . JUST TREAT IT LIKE OTHER ILLNESS WITHOUT Restrictive CAP.

ABSOLUTE CRITICAL NEED FOR ADDICTION COUNSELORS, BEDS AND TREATMENT. . . . Let's show our humanity by treating those in desperate need of mental health services in a hospital, or rehab and NOT A JAIL CELL OR THE STREETS.

Your shared concern is greatly appreciated.

Pat Ranney

THE TREVOR PROJECT

Saving Young Lives

Los Angeles—8704 Santa Monica Blvd., Suite 200, West Hollywood, CA 90069

New York—575 8th Ave., #501, New York, NY 10012

DC—1200 New Hampshire Ave., NW, Suite 300, Washington, DC 20036

p 310-271-8845 | f 310-271-8846 www.thetrevorproject.org

May 12, 2016

The Hon. Orrin G. Hatch, Chairman
The Hon. Ron Wyden, Ranking Member

¹Data as of November 10, 2015 presented by CMS at the MHA Regional Policy Council.

U.S. Senate
 Committee on Finance
 219 Dirksen Senate Office Building
 Washington, DC 20510

Dear Senators Hatch and Wyden:

The Trevor Project sincerely thanks you for recently holding a hearing entitled “Mental Health in America: Where Are We Now?” and asks that you immediately take steps to pass the Mental Health Reform Act (S. 2680). During the hearing it was very clear that our current mental health system needs a thorough overhaul, and Congress has a great opportunity to enact some of those key reforms by passing the Mental Health Reform Act (MHRA) of 2016. Thankfully, the MHRA has already been passed out of committee and is awaiting a vote on the floor of the Senate. We strongly urge you to request that Senate Majority Leader Mitch McConnell put the bill on the Senate agenda for a full vote as soon as possible. The MHRA is a truly bipartisan bill that addresses many current problems in the nation’s mental health system and also reauthorizes vitally important programs such as those created under the Garrett Lee Smith Memorial Act (GLSMA).

The Trevor Project is the leading national, nonprofit organization providing crisis intervention and suicide prevention services to lesbian, gay, bisexual, transgender and questioning (LGBTQ) young people through age 24. We work to save young lives through our accredited free and confidential lifeline, secure instant messaging services which provide live help and intervention, a social networking community for LGBTQ youth, in-school workshops, educational materials, online resources, and advocacy. Trevor is a leader and innovator in suicide prevention, especially as we focus on an important, at-risk population: LGBTQ youth.

When initially passed in 2004, the GLSMA created a suicide prevention grant program to allow states/tribes and colleges to engage in prevention efforts and allocated funding for the national Suicide Prevention Resource Center. Although the inaugural version of the Act expired in 2008, Congress has since continued to reauthorize the measure in recognition of the importance of youth suicide prevention by financially supporting Garrett Lee Smith programs.

The GLSMA currently needs to be reauthorized and is included in the MHRA, providing critical funding for the Suicide Prevention Resource Center (\$6 million annually), Youth Suicide and Prevention Strategy Grants to States and Tribes (\$30 million annually), and Mental Health and Substance Use Disorder Services and Outreach on campuses (\$6.5 million annually). Its funding currently supports suicide prevention programs in all 50 states, as well as the District of Columbia, and the continuation of this funding is necessary to the maintenance of these vital suicide prevention and mental health wellness services in schools and communities nationwide. Through the GLSMA’s administration by the Substance Abuse and Mental Health Services Agency, its funding is directed towards providing lifesaving services to individuals at risk of suicide, whether that is through providing mental health counseling; crisis intervention services; running a hotline; conducting a public awareness campaign; or training individuals on how to recognize a person in distress and to appropriately intervene.

Suicide is the second leading cause of death among children ages 10 to 24 in America, as well as the second leading cause of death on college and university campuses.¹ Lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth are at an exceptionally heightened risk for suicidal behavior: LGB youth are four times more likely, and questioning youth three times more likely, to attempt suicide than their heterosexual peers.² Additionally, almost half of young transgender people have seriously considered taking their lives, with approximately 25% having made at least one suicide attempt.³ LGBTQ youth who experience significant familial re-

¹Centers for Disease Control and Prevention. (2015). *Web-based Injury Statistics Query and Reporting System* [Data file]. Retrieved from www.cdc.gov/ncipc/wisqars.

²Kann, L., O’Malley Olsen, E., McManus, T., Kinchen, S., Chyen, D., Harris, W.A., Wechsler, H. (2011). Sexual Identity, Sex of Sexual Contacts, and Health-Risk Behaviors Among Students Grades 9–12—Youth Risk Behavior Surveillance, Selected Sites, United States, 2001–2009, *Morbidity and Mortality Weekly Report* 60(SS07), 1–133.

³Grossman, A.H. and D’Augelli, A.R. (2007). Transgender youth and life-threatening behaviors. *Suicide and Life Threatening Behavior* 37(5), 527. Retrieved from <http://transformingfamily.org/pdfs/Transgender%20Youth%20and%20Life%20Threatening%20Behaviors.pdf>.

jection are more than 8 times as likely to report at least one suicide attempt than their peers who come from welcoming, accepting family situations.⁴

These statistics are shocking and disheartening, but it is imperative to remember that together we can work to prevent suicide—through awareness and education, as provided by the GLSMA. Reauthorization of the Garrett Lee Smith Memorial Act will preserve the necessary funds for state and tribal organizations, as well as institutions of higher education, in order to allow these programs to continue serving youth in America who are at risk for suicidal ideation, behavior, and/or attempts.

With Congress's upcoming summer recess and its break for campaigning, the bills that are going to pass this legislative session must effectively be passed before the summer break, as we understand it is unlikely for Congress to convene during the lame-duck period. Therefore, we strongly urge you to request that Senate Majority Leader Mitch McConnell put the MHRA on the Senate agenda for a full vote *in the next 2 weeks*. The time has come for mental health reform and the MHRA represents the best opportunity among the last three decades to do just that.

Thank you for your time and consideration of supporting this critical piece of legislation, and for your commitment to improving the mental health of all Americans.

Sincerely,

Abbe Land
Executive Director and CEO



⁴Family Acceptance Project™. (2009). Family rejection as a predictor of negative health outcomes in white and Latino lesbian, gay, and bisexual young adults. *Pediatrics*. 123(1), 346–52.