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

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

**JUNE 16, 2015**

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

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

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

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

#### I. The Mental Health Crisis Facing America

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

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

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

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

<sup>1</sup> Shrinks: The Untold Story of Psychiatry. Little Brown 2015

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

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

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

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

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

<sup>1</sup><http://www.nejm.org/doi/full/10.1056/NEJMsa1413512>

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

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

<sup>1</sup> **American Psychosis: How the Federal Government Destroyed the Mental Illness Treatment System. Oxford University Press 2014**

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

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

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

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

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

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

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

## II. The Helping Families in Mental Health Crisis Act

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

