MEMORANDUM

May 15, 2014

To: Energy and Commerce Committee Members

From: Subcommittee on Oversight and Investigations Majority Staff

Re: Committee's Investigation of Federal Programs Addressing Severe Mental Illness

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Background

Fifty years have passed since President Kennedy signed the Community Mental Health Centers Act (P.L. 88-164), transforming the federal government's involvement in mental health. Despite that, for too long, mental health has been a topic kept in the shadows, often going unmentioned even as one in five Americans struggle with mental illness. A study, published in August 2013, has shown that mental and substance abuse disorders are notable contributors to the global burden of disease, being responsible for more of the global burden than are HIV/AIDS, tuberculosis, diabetes, or transport injuries.[1]

While the vast majority of individuals with schizophrenia, bipolar disorder, or major depression are not violent, those with untreated severe (or, used interchangeably, "serious") mental illness (SMI) are at an elevated risk of exhibiting violent behavior – two times, or greater, than the average person – directed at themselves or others.[2] There is considerable evidence that violent acts committed by mentally ill persons have increased over the past half century.[3] The reported presence of such disorders, largely left untreated, in recent perpetrators of mass violence – including Adam Lanza, in Newtown, Connecticut, James Holmes, in Aurora, Colorado, Jared Loughner in Tucson, Arizona, Aaron Alexis, at the Navy Yard in Washington, DC, and Army Spc. Ivan Lopez at Fort Hood, Texas – demands additional research, investigation, and understanding as to what went wrong.

The Committee on Energy and Commerce has been leading the way on addressing SMI following the tragedy at Newtown, CT.[4] As the Committee in the U.S. House of Representatives with jurisdiction over the key federal departments and agencies that play a role in mental health research and care, in January 2013, the Committee announced its intention to examine mental

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[1] Harvey A. Whiteford, *et al*., "Global Burden of Disease Attributable to Mental and Substance Abuse Disorders: Findings from the Global Burden of Disease Study 2010," *TheLancet.com*, published online August 29, 2013, *available at* http://press.thelancet.com/GBDsubstancementaldisorders.pdf.

[2] J. W. Swanson, *et al*., "Violence and Psychiatric Disorder in the Community: Evidence from the Epidemiologic Catchment Area Surveys," *Hospital and Community Psychiatry*, vol. 41, no. 7 (1990), 761 -770.

[3] E. Fuller Torrey, "Stigma and Violence: Isn't It Time to Connect the Dots?" *Schizophrenia Bulletin*, vol. 37, no. 5 (2011), 892-896, *available at* http://schizophreniabulletin.oxfordjournals.org/content/early/2011/06/04/schbul.sbr057.full.pdf+html.

[4] "A Mental-Health Overhaul: A Congressman Produces a Set of Good Ideas for a Difficult Problem," *The Wall Street Journal*, December 25, 2013, *available at* http://online.wsj.com/news/articles/SB10001424052702304367204579267030770210744.

health resources and programs across the federal spectrum.[5] Since then, the Subcommittee on Oversight and Investigations, under the chairmanship of Rep. Tim Murphy, a practicing psychologist, has held a series of public forums and investigative hearings aimed at discerning how federal dollars devoted to research and treatment into mental illness are being prioritized and spent. On December 12, 2013, Rep. Murphy introduced H.R. 3717, the "Helping Families in Mental Health Crisis Act," addressing many of the concerns raised by the Committee's investigation.[6]

Results of the Committee's Investigation

The Committee's probe has focused on three areas of critical public policy interest: (1) the scope of society's problem that is untreated SMI, (2) how privacy laws may interfere with patient care and public safety, including in mental health situations, and (3) how federal resources appropriated for research into and treatment of mental illness are being spent.

(1) Untreated Severe Mental Illness

To provide context for the Committee's investigation of federal priorities in addressing mental illness, the Subcommittee hosted a bipartisan public forum on March 5, 2013, "After Newtown: A National Conversation on Violence and Severe Mental Illness."[7] The forum brought together some of the nation's top mental health experts in the federal government and private practice, leading advocates, and parents to engage in an open dialogue on the state of the mental health system and treatment options for persons with SMI. Among the many issues discussed, the panelists highlighted for the Subcommittee how neither access to health insurance, nor the financial ability to seek help guarantee success in navigating the mental health system.

While recognizing that the vast majority of Americans with a mental illness are nonviolent and themselves are frequently the targets of violence, the Subcommittee heard how effective care continues to elude many of the estimated 11.4 million American adults suffering from SMI, placing their own lives, and sometimes those around them, at risk. For example, the Substance Abuse and Mental Health Services Administration (SAMHSA) estimates that in 2009, 40 percent of adults with SMI reported not receiving any treatment. Complicating matters further, on average, 110 weeks pass between the onset of symptoms and the individual entering into treatment.

As Director of the National Institute for Mental Health (NIMH) at the National Institutes of Health (NIH), Dr. Thomas Insel informed the Subcommittee that treatment can reduce the risk of violent behavior 15-fold in persons with SMI. A study, published in the journal *The Lancet* in May 2014, and examining over 80,000 subjects prescribed antipsychotics and mood stabilizers over three years – of whom a fraction were convicted of a violent crime during the study period –

[5] *Available at* http://energycommerce.house.gov/press-release/committee-leaders-announce-plan-review-range-programs-better-understand-what-can-be-done-prevent-tragedies-like-newtown.
[6] "Murphy Introduces The Helping Families in Mental Health Crisis Act," Press Release, December 12, 2013, *available at* http://murphy.house.gov/HelpingFamiliesInMentalHealthCrisisAct.
[7] *Available at* http://energycommerce.house.gov/event/after-newtown-national-conversation-violence-and-severe-mental-illness.

found that "[c]ompared with periods when participants were not on medication, violent crime fell by 45% in patients receiving antipsychotics and by 24% in patients prescribed mood stabilizers."[8] Yet, even today, as a result of a condition referred to by some as *anosognosia*, half of those individuals with SMI do not even recognize that they have a problem, may resist treatment, and may refuse to take medication that can help them recover.

Also discussed at the March 5, 2013, public forum was the effectiveness of various forms of involuntary commitment – including assisted outpatient treatment (AOT) – in reducing re-hospitalization, victimization, and incarceration in jails and prisons. This is of critical importance as the decrease in the number of public psychiatric beds due to deinstitutionalization has been accompanied by an increase in mentally ill persons who are homeless or confined to jails and prisons. Recent estimates of the number of persons with SMI range from 14.5 to 31 percent of the total prison population.[9] At some individual correctional institutions, half of all inmates have a mental illness. This trend also has been driven by the fact that many States continue to demand that an individual reach the point of posing an imminent danger, or "danger to self or others" before parents and others can intervene. A less rigid standard, that of "need for treatment," available in some States, allows for earlier intervention with safeguards built in to protect against abuses.[10]

These issues, among other far-reaching implications of the nationwide shortage of inpatient psychiatric beds, were examined in depth at a March 26, 2014 hearing before the Subcommittee, "Where Have All the Patients Gone? Examining the Psychiatric Bed Shortage," featuring testimony from witnesses in the fields of psychiatry, emergency medicine, law enforcement, the judiciary, the corrections system, and social services for the homeless.[11] Witnesses explained that the bed shortage had led to persons with mental illness ending up in prison due to non-treatment of their condition. It also had caused overcrowding in hospital emergency rooms where patients with mental illness are boarded for hours or days awaiting for a bed to open up.

Dr. Jeffrey Geller, a psychiatrist and professor at the University of Massachusetts, testified, in particular, that the bed shortage has been exacerbated by a Medicaid billing policy known as the "Institutions of Mental Disease" (IMD) exclusion, which prohibits federal matching payments for inpatient care of enrollees at psychiatric hospitals with more than 16 beds.[12] States have adjusted their Medicaid programs to maximize reimbursement from the federal government, while closing off access to inpatient treatment for acute psychiatric illnesses.

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[8] Seena Fazel, *et al*., "Antipsychotics, Mood Stabilisers, and Risk of Violent Crime," *TheLancet.com*, published online May 8, 2014, *available at* http://download.thelancet.com/pdfs/journals/lancet/PIIS0140673614603792.pdf?id=qaaz76KqVrkpTeOy2e8xu.

[9] Henry J. Steadman, *et al*., "Prevalence of Serious Mental Illness Among Jail Inmates," *Psychiatric Services*, vol. 60, no. 6 (June 2009), 761-765, *available at* http://ps.psychiatryonline.org/data/Journals/PSS/3881/09ps761.pdf.

[10] Pete Earley, "Deeds Attack Shows That Our System is a Mess," *USA Today*, November 20, 2013, *available at* http://www.usatoday.com/story/opinion/2013/11/20/pete-earley-creigh-deeds-mental-illness/3654793/.

[11] *Available at* http://energycommerce.house.gov/hearing/where-have-all-patients-gone-examining-psychiatric-bed-shortage.

[12] Written testimony of Jeffrey Geller, MD, *available at* http://docs.house.gov/meetings/IF/IF02/20140326/101980/HHRG-113-IF02-Wstate-GellerJ-20140326.pdf .

(2) Troubles with the Privacy Rule

The inability or unwillingness of some patients to recognize a problem and begin treatment, mental health or otherwise, elevates the importance of an individual's family and friends in any successful effort to obtain care for them.[13] Parents, sharing powerful stories of their experiences trying to get treatment for their mentally ill children in the current system, expressed concerns at the March 5, 2013 public forum that the Health Information Portability and Accountability Act's (HIPAA) privacy rule may interfere with the timely and continuous flow of health information between health care providers, patients, and families, thereby impeding patient care, and in some cases, public safety.

Generally, HIPAA prohibits covered entities from using or disclosing protected health information, except as expressly permitted or required by the rule. Aside from giving patients the right to examine and obtain a copy of their health records and to request corrections, the privacy rule sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. Studies show that some health care providers apply HIPAA regulations overzealously, leaving family members, caregivers, public health, and law enforcement hindered in their efforts to get information.

On April 26, 2013, the Subcommittee held a hearing entitled "Does HIPAA Help or Hinder Patient Care and Public Safety?" featuring parents, caregivers, trained health care providers, legal experts, and the HHS official charged with enforcing HIPAA.[14] Witness testimony was replete with accounts of thwarted efforts by families and other caregivers to obtain information about a sick family member or even to share pertinent information with the family member's treating physicians. While some experts blamed the language of the law itself for its inconsistent application, noting the broad discretion to disclose information left with the health care provider, others pointed out that many providers may not understand the law, have not trained their staff to apply it reasonably, or are fearful of the threat of fines and jail terms resulting from noncompliance. Such over-caution often results in the failure to disclose protected health information even when disclosure is merited by the circumstances and is nowhere prohibited.

In response to a Question for the Record (QFR) from the Committee, officials of the Office for Civil Rights (OCR), the office delegated the authority of the Secretary of Health and Human Services (HHS) to administer and enforce the privacy rule, affirmed that their focus "is on systemic security problems and longstanding failures of certain entities to fulfill individuals' rights under the Privacy Rule" and not good faith efforts by health care providers to comply with the privacy rule while communicating with patients' family members and friends. In response to another QFR, OCR assured the Committee that "HIPAA in no way prevents health care providers from listening to family members or other caregivers who may have concerns about the health and well-being of the individual, so the health care provider can factor that information into the individual's care."

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[13] Gary Fields, "Families of Violent Patients: 'We're Locked Out' of Care," *The Wall Street Journal*, June 7, 2013, *available at* http://online.wsj.com/news/articles/SB10001424127887323463704578495154217291958.

[14] *Available at* http://energycommerce.house.gov/hearing/does-hipaa-help-or-hinder-patient-care-and-public-safety.

While HHS's stated aim of focusing on "systemic" problems is laudable, it is not clear that HHS is doing everything it must to increase public awareness of the privacy rule's purpose, defuse misconceptions surrounding its enforcement, and clarify the importance of action, where common sense and the interest of the patient and the patient's family demand it. On February 20, 2014, possibly in response to concerns raised at the Committee's April 26, 2013 hearing, OCR released revised HIPAA guidance providing clarification, including that health care providers are permitted to inform the family members of a mental health patient "who has capacity and indicates that he or she does not want the disclosure made," if the patient constitutes a "serious and imminent" threat to the health or safety of self or others, and if the family members are in a position to lessen or avert the threat.[15]

Unfortunately, as long as misconceptions or ignorance of the rights and responsibilities associated with the privacy rule persist, HIPAA may continue to hinder necessary communication – including in such common, good faith instances – with significant implications for patient care and public safety. Therefore, it may be worthwhile to explore establishing lower barriers for families who, in good faith, seek information about a family member with SMI to protect their health or safety, particularly where that individual is unable to fully understand or lacks judgment to make an informed decision regarding their need for treatment, care, or supervision.

(3) Federal Resources Devoted to Mental Health

To ensure that federal resources are effectively used, it can be helpful to itemize federal spending on mental health programs. As no such compilation of federal programs related to mental health was publicly available at the onset of the Committee's investigation – and to the best knowledge of the Committee had not been undertaken previously for internal government-wide use, planning, or coordination purposes – on April 10, 2013, the Committee requested that the Office of Management and Budget (OMB) produce a comprehensive inventory of federal programs supporting mental health research, prevention, and treatment.[16] The Committee received OMB's response in a letter dated November 7, 2013 (see Attachment), disclosing federal government-wide outlays on mental health for the first time.

In brief, OMB reported that in fiscal year (FY) 2012, $130 billion in federal funds – of which, $13 billion were discretionary and $117 billion were mandatory – were directed to mental health surveillance, research, prevention, and treatment activities, as well as income support and other social services for individuals with mental illness. Of this total, in FY 2012, just over $40 billion was paid out under Medicare and Medicaid programs, approximately $2 billion at NIH, and over $1 billion at SAMHSA. In addition to HHS agencies, in FY 2012, mental health research, prevention, and treatment activities across the Department of Defense amounted to $2.9 billion, and nearly $6.5 billion at the Department of Veterans Affairs. On top of that, in that same year, income support and other social services for individuals with mental illness were funded at $1 billion by the Department of Education and nearly $76 billion by the Social Security Administration.

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[15] *Available at* http://www.hhs.gov/ocr/privacy/hipaa/understanding/special/mhguidancepdf.pdf.
[16] *Available at* http://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/letters/20130410OMB.pdf.

Noting limitations on any attempt to estimate all federal mental health spending in any given year, OMB explains that there are a number of other federal programs that address mental health as part of broader activities, but do not track funds directed to the mental health component. This would include, for example, federally funded activities targeted to address substance abuse, but that benefit individuals with co-occurring substance abuse and mental illness. There are also federal services or benefits provided to individuals with mental illness that are not furnished exclusively on the basis of the individual's mental illness – for example, in FY 2012, an additional $125 billion in federal funds supported broader activities that include a mental health component and services that support a population that includes individuals with mental illness who are not separately identifiable.

Focusing in on HHS Spending, and SAMHSA in particular

The Committee's investigation of mental health spending concentrated on programs administered by HHS, host to both NIH, the lead federal agency for supporting biomedical and behavioral research, and SAMHSA, the lead federal agency for increasing access to mental health and substance abuse treatment and prevention services.

The majority of NIH's spending for mental health research is administered by NIMH. The National Institute on Drug Abuse, the Eunice Kennedy Shriver National Institute of Child Health and Human Development, the National Institute of Neurological Disorders and Stroke, and the National Institute on Alcohol Abuse and Alcoholism also support some research in mental health. In FY 2011, NIMH's total program-level funding (including extramural research, intramural research, and research management and support) was $1.475 billion. In FY 2012, this figure rose slightly to $1.479 billion.

SAMHSA, whose mission is split between mental health and substance abuse treatment and prevention services, enjoyed program-level funding of $3.599 billion in FY 2011 and $3.565 billion in FY 2012. Of that total, SAMHSA's Center for Mental Health Services (CMHS) received $1.022 billion in program-level funding in FY 2011 and $0.999 billion in FY 2012, supporting access to mental health services through various grant programs. Competitive grants for mental health, substance abuse treatment, and substance abuse prevention account for about one-third of SAMHSA's budget. Formula grant programs for mental health, substance abuse treatment, and substance abuse prevention account for the other two-thirds of the agency's budget.

With the aim of taking a closer look at how SAMHSA puts federal dollars to use, on May 22, 2013, the Subcommittee held a hearing, "Examining SAMHSA's Role in Delivering Services to the Severely Mentally Ill," featuring SAMHSA Administrator Pamela Hyde, a panel of outside experts, and an individual whose family had been seriously impacted by SAMHSA's programs.[17] Ms. Hyde was confronted over Member and witness concerns that SAMHSA – being preoccupied with more moderate forms of mental illness, broadly defined behavioral health concerns, or emotional disturbance – was insufficiently focused on addressing those

[17] *Available at* http://energycommerce.house.gov/hearing/examining-samhsas-role-delivering-services-severely-mentally-ill.

hardest-to-treat cases of SMI, for which inaction carries the greatest risks to the patient and surrounding communities, as illustrated in the recent cases of Adam Lanza and Aaron Alexis. Furthermore, individuals with SMI consume a greater proportion of public resources – healthcare, social services, and criminal justice – relative to their overall population. The city of San Francisco identified the 477 largest consumers of emergency health services; more than a quarter of the individuals had schizophrenia.[18] Miami-Dade County identified 97 individuals, mostly men with untreated schizophrenia, who were arrested 2,200 times and spent 27,000 days in jail over a five-year period at a cost of $13 million.[19] In the State of Maryland, just 500 patients cost the State's Medicaid program $36.9 million largely due to repeat hospitalizations.[20]

In response to a QFR probing SAMHSA's funding priorities, Ms. Hyde wrote that "SAMHSA's role is not limited to certain mental illnesses or a small number of mental health conditions. . . SAMHSA is concerned about all Americans, whether they are in need of prevention or whether they are facing mild, moderate, or serious and persistent mental health issues." Nonetheless, SAMHSA claimed to have allocated approximately 81 percent of the FY 2013 CMHS budget to support "adults with and at risk for serious mental illness and/or children with serious emotional disturbance [SED]."

While several of SAMHSA's programs, such as the Community Mental Health Services Block Grants, are required statutorily to support services treating adults with SMI and children with SED, among others, SAMHSA did not provide the Committee with further evidence that these dollars are reaching the most at-risk individuals. Interestingly, OMB, in its November 7, 2013 response to the Committee's bipartisan request of April 10, 2013, neglects to address, at all, the subpart of the Committee's inquiry demanding information on "the amount of such funds that are used to support efforts to address serious mental illness."

Witnesses also spoke of troubling gaps in the integrity of the agency's grant screening process, inadequate responses to potential violations of federal lobbying prohibitions by certain grantees, as well as instances of grantee activism seemingly at odds with the science of psychiatry and SAMHSA's founding mission. In testimony delivered at the May 22, 2013 hearing, Dr. E. Fuller Torrey, founder of the Treatment Advocacy Center, noted that "SAMHSA has funded similar organizations under its consumer grant program and its Protection and Advocacy grant program that have *actively impeded the implementation of improved treatment laws* [like AOT] in many other states," (emphasis added) including Maine and Pennsylvania. These concerns were most dramatically illustrated in testimony delivered by Joe Bruce, a Maine resident whose story was featured in a 2008 article in *The Wall Street Journal*.[21]

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[18] R. Jan Gurley, "Meet San Francisco's 477 Most Expensive High Utilizers of Medical Services," *Reporting on Health*, May 3, 2011, *available at* http://www.reportingonhealth.org/blogs/meet-san-franciscos-477-most-expensive-hums-high-utilizers-medical-services.

[19] Jan Pudlow, "Stop Treating Mental Illness as a Crime," *Florida Bar News*, December 1, 2013, *available at* http://www.floridabar.org/DIVCOM/JN/JNNews01.nsf/RSSFeed/C2729BF949577C1B85257C2E0048EA93.

[20] John J. Boronow and Stephen S. Sharfstein, "Close the Mental Health Revolving Door," *Baltimore Sun*, December 29, 2013, *available at* http://articles.baltimoresun.com/2013-12-29/news/bs-ed-commitment-20131228_1_poor-patients-illness-treatment.

[21] Elizabeth Bernstein and Nathan Koppel, "A Death in the Family," *The Wall Street Journal*, August 16, 2008, *available at* http://online.wsj.com/news/articles/SB121883750650245525.

In 2006, Joe's wife, Amy, was murdered by their son, Will, only months after being released from a psychiatric center where he had been treated for schizophrenia. Joe believed that the efforts of the SAMHSA-funded Disability Rights Center, based in his home State of Maine, obtained his son's premature release from the hospital without putting in place a mechanism for ensuring that Will would remain on his medications. Ultimately, it took the death of Joe's wife at Will's hands to get Will on a consistent medication regime to treat the symptoms of his schizophrenia.

In 2009, Will wrote to members of the Maine State Legislature's Health and Human Services Committee in support of LD 1360, a bill adopting AOT, thereby improving Maine's ability to provide treatment to people with severe mental illnesses by allowing for outpatient commitment as an alternative to inpatient hospitalization. LD 1360 was signed into law by Maine Governor John Baldacci, on April 14, 2010, despite efforts by the Disability Rights Center, and several other organizations, to defeat it.[22]

While noting SAMHSA's status as a component of the U.S. Public Health Service and the Federal government's lead agency for reducing the impact of mental illness on America's communities, the hearing raised concerns about SAMHSA's commitment to recruiting individuals with genuine scientific expertise. For unknown reasons, SAMHSA was not forthcoming in sharing with the Committee the fact that, as of August 2013, the agency of 534 employees employed no more than 4 M.D. psychiatrists – a surprisingly low figure given SAMHSA's designation as the lead federal agency for increasing access to mental health, handling a mental health-related budget of over $1 billion. Although this information – as well as general figures regarding the educational backgrounds of SAMHSA's staff – initially was requested by the Committee in a May 8, 2013 letter to SAMHSA[23] and Ms. Hyde was unable to provide a response at the May 22, 2013 hearing, it finally was answered in an email to Committee staff dated August 19, 2013.

In response to a QFR requesting whether the agency requires those that evaluate grant applications for science quality and integrity hold advanced degrees in social work, psychology, and psychiatry, Ms. Hyde responded that "[r]eviewers often have advanced degrees related to the mental health/prevention/treatment field and decades of experience." Throughout discussions with Committee staff, SAMHSA officials have noted the valued role played by individuals with mental illness, or "consumers," in the grant screening process. Such individuals may have no specialized training as mental health professionals, their qualification to serve as grant reviewers resting simply on a medical diagnosis and resulting "lived experience." While affirming that grant reviewers are required to sign a form attesting that they do not have a conflict of interest with any of the applications under review, SAMHSA provided no evidence of efforts preemptively to identify or root out instances of fraud or abuse that may arise in this manner.

Members also raised concerns about SAMHSA's commitment to ensuring post-award grantee compliance with the terms of their grants, including federal law. For example, witnesses

[22] Disability Rights Center News, Summer 2009, *available at* http://www.drcme.org/uploads/Newsletter_2009.pdf.
[23] *Available at* http://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/letters/20130508SAMHSA.pdf

described recipients of certain formula grants engaging in what appeared to be prohibited lobbying activities at the State level – one, specifically, opposing a proposed tightening of civil commitment laws. In response, SAMHSA indicated that all applicants are made aware of the prohibition on using federal funds for lobbying and, if applicable, must complete a Disclosure of Lobbying Activities. SAMHSA acknowledges that "[e]ntities designated to receive these Federal funds may have other sources of funding" that could be used for lobbying. However, with between 95 to 98 percent of total operating revenue for many PAIMI grantees coming from federal sources, it defies credulity that extensive lobbying activities are paid for solely with private donations or State or local funding. Short of affirmatively requiring a segregation of and detailed accounting for the use of federal versus non-federal funds, it will be difficult – if not impossible – to deter or prevent these kinds of abuses.

The hearing drew attention to troubling activities undertaken by SAMHSA grantees and the agency's limited ability and/or willingness to rein them in. For example, Chairman Murphy referenced anti-psychiatry views expressed by participants at numerous SAMHSA-funded conferences – including an instance in which individuals with mental illness were encouraged to go off their physician-prescribed medicine. In response, Ms. Hyde confirmed that SAMHSA "fund[s] a number of conference efforts and others" but "[w]e do not go inside each individual presentation to identify whether or not we agree with each individual presenter." Responding to a question from Ranking Member Diana DeGette as to whether some SAMHSA-funded patient advocacy groups may in fact advise individuals not to take their psychotropic drugs, Ms. Hyde responded "[t]hey very well may. . . . Those groups may have that policy," all while SAMHSA continues to fund such organizations and conferences to the tune of millions of dollars per year.

Conclusion

Perpetrators of recent mass killings linked to untreated SMI, whether Seung-Hui Cho or James Holmes, Jared Loughner or Adam Lanza, all exhibited a record of major psychiatric problems prior to their crimes. More recently, in November 2013, even an emergency custody order following a psychiatric examination was not enough to prevent Austin Deeds from being released from a treatment center citing lack of beds; upon release, he proceeded to stab his father, Virginia State Senator Creigh Deeds, before killing himself.

None of these cases are attributed to the failure or inability of mental health professionals to make an early identification of the perpetrator's mental illness. Rather, the critical factor missing in these cases was any assurance that such individuals would obtain, and remain under, effective psychiatric treatment. In the Deeds case, the dire implications of the nationwide shortage in quality outpatient, community treatment programs and inpatient psychiatric beds – the latter being a function of the sharp decline in the capacity of State psychiatric hospitals over the past several decades resulting from deinstitutionalization and the IMD exclusion – were prominently featured.

The Committee's inquiry has drawn attention to the importance of targeting funds for mental health to areas with the greatest impacts on public health and safety. This may require, in certain instances, reprogramming the federal government's support for programs to those shown to deliver the most positive health-related outcomes for individuals with SMI, improving the

prospects for recovery of those currently not receiving proper treatment. The revelation that federal spending on mental health exceeded $130 billion in FY 2012, including $54 billion for surveillance, research, prevention, and treatment activities alone illustrates the importance of improving coordination across agencies to combat waste and duplication.

The findings of the Committee's investigation underscore the need to improve training for law enforcement and emergency medical services personnel on mental health issues. They also demonstrate the importance of training primary care physicians in mental healthcare, noting the interconnectedness between medical and mental health problems, while working toward a better integration of psychiatric and primary care, particularly as psychiatrists remain in short supply.

Due to the effects of *anosognosia*, many individuals with SMI have difficulty acknowledging that they have a legitimate psychiatric diagnosis, let alone following through on a physician-approved treatment regimen. For this population, re-hospitalizations and re-incarcerations can be quite common. Where they have been implemented, alternatives to long-term inpatient care, such as AOT, have been proven to save money for State and local governments by reducing the rates of imprisonment, homelessness, substance abuse, and costly emergency room visits by the chronically mentally ill. Where possible, expansion of federal incentives for States and localities to experiment with AOT may encourage a more humane, supervised, and results-oriented reintegration of individuals with SMI into their communities.