morning, inviting in many of the business interests along the seaway and looking for ways in our transportation bill where we can make more investment in that region so it can sing fully economically again.

So I thank the gentleman for a moment here. And believe me, I unite with you in your efforts to make America fully strong again, and Make It In America can lead us down that path.

Mr. GARAMENDI. You have been a leader on these issues for many, many years and certainly in your territory of Ohio. You saw what happened when the manufacturing plants left; but they are coming back, and we can make policy to do that.

I think you may have other things that you would like to bring to our attention. You are certainly welcome to do so.

I think with that, it is time for me to say ''enough,'' or maybe I have said too much already.

Madam Speaker, I yield back the balance of my time.

MENTAL HEALTH WEEK

The SPEAKER pro tempore (Ms. MCSALLY). Under the Speaker's announced policy of January 6, 2015, the gentleman from Pennsylvania (Mr. MURPHY) is recognized for 60 minutes as the designee of the majority leader.

Mr. MURPHY of Pennsylvania. Madam Speaker, this evening, just before votes, I went outside on the balcony here of this Capitol to watch the sun set. It was one of those beautiful evenings of crimson and gold and gray clouds silhouetted against the twilight glow of the evening. And then I glanced over to the buildings here at the Capitol and was suddenly brought back to reality when I saw so many flags on our buildings flying at half mast, flying at half mast because, once again, we are remembering the tragedies that have shaken our Nation time and time again.

This has been a bloody summer, a bloody summer of many attacks that have been associated with folks with mental illness.

I know most people with mental illness are not violent, and I know that there are many other tragedies that occur; but tonight, during this week, which is Mental Health Week in America, I want to highlight, Madam Speaker, what we must do as a nation, what we cannot continue to push aside.

Just think of what happened this summer, just a few examples:

June 13, attack on the Dallas Police headquarters by a man who had a history of family violence and mental instability;

July 23, Lafayette, Louisiana, a shooting in a movie theater by a man who had had a judge's orders to send him to a mental hospital in the past;

August 16, Antioch, Tennessee, a movie theater attack;

August 26, Roanoke, Virginia, a live, on-air shooting, a tragic scene of a reporter being killed, and a cameraman;

August 28, 2015, Houston, Texas, while a deputy police officer was at a gas station, riddled with bullets by a man who had a history of mental illness;

September 22, the son of a State senator, former State senator of Virginia, killed a man, and also killed himself in Bowling Green;

And this last week, October 1, in Roseburg, Oregon, nine people were killed, and the gunman killed himself in another tragic scene.

There is more to it than this, of course. In this country last year, 125 people with mental illness were killed in some sort of a police shooting where the police oftentimes did not even know, but the confrontation grew and ended in a death.

It is estimated there were somewhere between 1,200 and 1,500 murders in this country this last year by people with mental illness. But more than that, there are 10,000 or more, maybe 20,000, maybe 100,000 people with mental illness who are the victims of crime. Some are killed.

There are thousands and thousands of people who are homeless, who die that slow-motion death of homelessness, of their physical ailments and their illnesses.

There were 41,000 suicide deaths, 1.2 million suicide attempts that required some medical care, 43,000 substance abuse overdose deaths. This list goes on and on and on.

And what happens is, when we treat people with mental illness early in their life, their prognosis is improved. In many cases, they can go on to have fruitful lives. But when it is untreated, they likely develop other problems, not just with mental illness, but social, job, and physical health.

Persons with serious mental illness, in treatment, are 15 times less likely to engage in an act of violence than those who are not in treatment.

□ 2015

In America, some 60 million people in any given year will have some diagnosable mental illness, from the very mild and transient ones, which we all experience, to severe mental illness, such as schizophrenia or bipolar or extreme depression. But of those with serious mental illness, about 4 million of those 11 million will not have any treatment for a variety of reasons: treatment may not be available; they may refuse treatment; or what happens so often with those with serious mental illness, they are characteristically unaware that they have an illness—it is a brain illness, a serious mental illness—like a person with Alzheimer's or stroke or traumatic brain injury, a person who may not even know that they have a problem.

What do we do about this as a nation? Mostly we just talk. Sadly and tragically, what we do here in the House of Representatives, we will have a moment of silence, but it is not followed by action. What we need is not more silence. We need action.

Madam Speaker, we need people in this country to rise up and say: This is the time. This is the day. This is the issue where we are, once and for all, going to do comprehensive reform of our mental health system in America.

Our mental health system in America is fragmented at best, a system with regulations that are abusive and neglectful towards those with serious mental illness. And more so, it is worse if you are a minority or low-income.

This is odd because in a field that is filled with some of the most compassionate and caring people I know, people I have had the pleasure to work side by side with in my role as a psychologist, we have Federal policies and State policies that leave their hands tied, their eyes blinded, and their mouths gagged to prevent treatment from occurring. Ultimately, the individuals suffer and their families suffer.

Tonight we will review what the problem is and what can be done systemically, thoroughly, and definitively, what this country must do if we are serious about treating mental illness.

One of my colleagues from the Toledo area, who represents northern Ohio, is with us now. I yield to the gentlewoman from Ohio (Ms. KAPTUR).

Ms. KAPTUR. I thank you, Congressman MURPHY, for yielding to me. I want to say how fortunate the country is that the people of Pennsylvania have elected you here to serve the people of our Nation with the strong background that you have and with the obvious depths of knowledge that you have about those who are mentally ill and the compassion you have in a field that is very difficult, where the answers still remain incomplete.

I want to be on the floor this evening to say to those who are listening in the Chamber, to those who may be listening outside, your efforts to draft the Helping Families in Mental Health Crisis Act, H.R. 2646, is a watershed moment in this Congress.

I have served in this Congress a lot longer than the others on the floor this evening. I was here in 1998 when, sadly, we lost two of our Capitol Police officers, Jacob Chestnut and John Gibson. A diagnosed schizophrenic receiving Federal SSI benefits but off his medicines and estranged from his family headed on a rampage all across the country, all the way from the West to here, and delusionally, he set out to quash, I guess, a purple force he had tracked here to the Capitol.

He broke into the majority leader's office. All the staff went under the desks. I thought, well, maybe this is the moment that Congress will finally face up to the violent impulses that have fallen right at our knees. I said, but I would wager one of two things will happen: either we will finally cut the mustard and do what is right, or we will have more barricades and armed officers. Well, it was the latter option that actually happened.

As we mourn the deaths of nine innocent victims at Umpqua Community

College, I commend Congressman MURPHY of Pennsylvania for putting a bill forward that forces us to probe deeply the pattern of these mass shootings. We need to know the perpetrators.

We understand the perpetrator in Oregon had served in the U.S. military for a very brief time. He was discharged. And my question to the U.S. military is: Why? Why was he discharged? Did you discharge him to care if you saw a pattern that needed treatment? Or did you close your eyes too? Because that has happened repeatedly in the U.S. military, though I must say that they are doing a little bit better, because some of their own members have now been killed around the country because of individuals who face very severe illnesses in their own lives and have simply never had the kind of doctor to help them come out of the dark shadows of the existence in which they have been living.

Many of these individuals have been abandoned by their families. Many times they are expelled from school.

As you look around the country and you see the people who commit these heinous, heinous crimes and then many times take their own life, they are completely alone or they are living with one member of their family, abandoned by their other family members and, as the gentleman from Pennsylvania has said, many times ending up homeless, the victims of attacks themselves, or many times, out of whatever is happening in a very ill brain, taking it out on the rest of society.

Probing deeply into mental illness requires a discipline that Congressman MURPHY has and an understanding that no Congress yet has had. That myopia is symptomatic of what is happening across our Nation: more security but no significant attention to those who show out-of-control and violent tendencies, those tragically mentally ill citizens who are driven by their illness to harm others.

If someone has a broken back, we have special wards. What happens to the mentally ill in the district that I represent and across this country, some of them end up in the jail. Seventy-five percent of those incarcerated in northern Ohio have dual diagnoses of mental illness and substance abuse. What does that tell us? Our jails have become the depositories for this Nation's mentally ill.

I am not saying that individuals diagnosed with mental illness are more likely to commit crimes. I agree with Congressman MURPHY that most of them become victims of crimes because they aren't thinking straight, and it doesn't have to be this way.

The bill that Congressman MURPHY has written and has vetted and has worked with different groups and individuals, and which I support and a host of other Members do on a bipartisan basis, is supported by one of the most important organizations in our country: the National Alliance on Mental Illness. I have the highest respect for them.

H.R. 2646 fixes the Nation's broken mental health system by refocusing programs, reforming grants, and removing Federal barriers to care. It names an assistant secretary for mental illness at the Department of Health and Human Services, and it encourages more meaningful involvement from family members and caregivers who, frankly, at this point, many times, just give up because they have this force within their homes that they cannot contain.

Rather than just paying tribute to those among us who have been lost and those who save them at risk to their own lives, cannot we elevate the solution to efforts that could help to prevent further tragedies?

We think about the Capitol shootings. We think about Sandy Hook. We think about Virginia Polytechnic. The U.S. leads the world in mass shootings. There have been 294 mass shootings in 2015 alone, and each one gives us an indicator of the possible sign of untreated mental illness. Each one represents a failure of our society, and dispelling the stigma of mental illness for those who suffer remains a task unfinished.

When do the elected Representatives of the American people say, ''Enough. America can do better. America must do better''? Let's create a pathway, by passing H.R. 2646, to immediate treatment for those mentally ill citizens dangerous to others and dangerous to themselves.

Congressman MURPHY, I can't thank you enough. I don't recall a bill which has had such broad bipartisan support. You have worked so hard to go around the country. This is not a partisan issue; this is an American issue. I hope America can lead the world in trying to find a better way.

The suffering that we see in our districts, in community after community after community, broken families, broken people, this doesn't have to be in our country.

In the hearing that you conducted in Cleveland, I learned something really important that I didn't know, and that is that in the way that the reimbursement occurs to hospitals for people seeking care, that research in mental illness is at the bottom of the list because reimbursement doesn't flow the same way. So as we try to find answers to what is going on in the human brain, with the secretion of such chemicals like dopamine and serotonin and these different chemicals that those who are healthy have being secreted at a normal level, those who do not have that system working for them have big problems; but yet, if doctors try to get research dollars to solve and figure out what is going on in the human brain, the reimbursement system we have today simply doesn't work. I didn't know that.

So I thank you for coming to Ohio because I am focused on that like a laser beam, and it is a part of the answer. So thank you for allowing me some time tonight on the floor. The people I represent thank you. We want to help you. I hope those listening will find cosponsors from their different parts of the country to help you move this bill forward. We couldn't do anything more important for the country. Thank you.

Mr. MURPHY of Pennsylvania. Madam Speaker, I yield to the gentlewoman from North Carolina (Mrs. ELLMERS), a member of the Energy and Commerce Committee and a cosponsor of this bill.

Mrs. ELLMERS of North Carolina. Thank you to the gentleman from Pennsylvania.

I, too, want to thank him for his tireless work on this effort. This is such an important piece of legislation in dealing with mental health and putting necessary reforms in place. The gentleman has truly been an absolute champion on this issue, and H.R. 2646 is such a meaningful piece of legislation that will help in so many different ways.

Mental health in this country is a crisis and it is an epidemic, and there are so many families across this country that are dealing with this issue.

The gentleman came to my district a little over a year ago, and we had a wonderful roundtable discussion. There were so many individuals who came to it, so many family members who came to it to speak on this issue. They were so appreciative of the fact that there was actually some legislation that was being developed to deal with this issue. These are families that have nowhere else to go.

In my experience as a nurse, in health care, but then also as my experience has gone forward in taking care of those in my district and then traveling across the country and meeting with families and talking with individuals about how much this affects their lives, and it is almost amazing when you start having the conversation about this piece of legislation because I don't even think they think that anybody wants to help them anymore. I think they feel so far and left behind that it isn't even in their mind that someone is out there looking for an answer and helping in a way that will be meaningful into the future.

The gentleman from Pennsylvania has done extensive work with so many groups, so many patient advocacy groups. His own personal knowledge as a child psychologist has played into this issue. There are certain barriers that are in place, and they are in place because we have put them there. Well-meaning, well-intended HIPAA laws, all of these things that have been put in place to help protect patients and their privacy and their issues, yet it prevents us from being able to understand the situation. It prevents families from being able to get care for their loved ones.

Maybe an adult child of parents who are struggling to help their child, their son, their daughter. They may be out

on the streets; they may be at home; they may have issues; they may not be working. I mean, there are so many different things that can be happening, and they know that that individual needs help, and they have no one to go to.

□ 2030

Madam Speaker, this legislation will change much of that. It is a step in the right direction. There is much more that needs to be done. We were just talking a moment ago about our jails, our prisons, and how many of those who are within those walls and behind those bars literally are there because they have mental health issues. Yes, they may have committed a crime; yes, they may have found themselves in a terrible situation and ended up in jail, possibly even drug abuse; but the bottom line is the mental health issue that lies there.

We are talking even about issues of fiscal responsibility in this country, and I think of how much money we will save and how much of a difference it will make if we deal with this issue in the way that it needs to be dealt with.

So, Madam Speaker, I am a cosponsor of this legislation. This is an incredibly important piece of legislation. It is bipartisan, and it is for every American in this country, every American in this country that is dealing with this issue with a loved one or with a friend. We all have them. We all walk down the streets and see individuals who we know are homeless, and we know that the root cause is mental illness. We can change something in this country. This is one change we need to make. We need to come together as a whole House of Representatives to pass this piece of legislation.

Again, I just want to finish by thanking the gentleman from Pennsylvania one more time for his tireless efforts. You have truly been the champion for every mental health issue, and this piece of legislation passed by the House of Representatives will be a monumental step in the direction of mental health reform.

Mr. MURPHY of Pennsylvania. I thank the gentlewoman for her comments and for her continued pursuit of making sure we pass this.

This bill was first introduced over a year ago, reworked with a lot of bipartisan input, Members of Congress from both sides of the aisle, and also from many, many organizations. The other day, some 23 organizations delivered a letter to some Members of Congress saying they want to see comprehensive mental health reform.

This is the first and the most comprehensive mental health reform our country has seen. The last time some efforts were made, it was the very last bill that President Kennedy signed before he was assassinated to begin to make some change in our country to move away from the asylums and towards community mental health. Unfortunately, that dream only came partially true because what happened is we closed those asylums.

Back in the 1950s, we had 550,000 psychiatric hospital beds in this country. At that time the population of the country was 150 million. Now the population of the country is over 316 million, 320 million, and we only have 40,000 psych beds.

Now, Madam Speaker, some of that is because we have come up with more effective treatments, better ways of identifying and diagnosing people, better medications, and, quite frankly, those asylums of yesteryear needed to close. Many times they were homes of abuse and given nicknames like snake pits, cuckoo's nests, and other derogatory terms because they were so bad. But then along came community medical health centers, and that was supposed to pick up the slack. As States found that they could close these asylums, they looked and saw that they could save some money, and they didn't put the money into mental health services, nor did the Federal Government. What happened instead was the people traded the hospital bed for the jail cell, for the homeless shelter, and for the morgue. That is where we are today.

Now, it is not for lack of trying because, indeed, the Federal Government has spent a lot of money—some $100-plus billion a year—on this, mostly through disability payments, but some for Federal programs.

Madam Speaker, what I want to do tonight is now talk about 10 things we can do as a nation to deal with this, 10 things we must do.

First of all, the General Accounting Office report that we commissioned from the Energy and Commerce Committee, we said: Tell us what programs there are in the Federal Government that deal with mental health and, more specifically, serious mental illness.

I was amazed to hear how many there were, 112 agencies scattered across eight departments. It is a dysfunctional and uncoordinated system. It is a system that really does not have central control. It is a system that has not even met among these agencies for years, even though one of the agencies, SAMHSA, Substance Abuse and Mental Health Services Administration, is supposed to be the lead agency to say get together and meet. They hadn't even met since 2009.

By the way, when we had a hearing on this in the Oversight and Investigations Subcommittee, they said: Oh, we will start doing that soon. But this report that came out that excoriated the Federal programs said that they are not only uncoordinated, but nobody even checks to see if what they do works. They are programs with the Department of Defense; Veterans' Affairs; Education, Health and Human Services; HUD. The list goes on and on. I think there are 20-plus programs for homelessness. There was redundancy and there was overlap, but it is not coordinated. We make it the most difficult for those who have the most difficulty.

So here is number one of what we want to do. We want to have the office of the assistant secretary for mental health and substance abuse created—a new office, but not new money. We do not need any money for this. We take the current office of SAMHSA and elevate that title of the person who runs that agency to the level of an assistant secretary. That person's job will be to create an annual report to Congress to tell us the state of the States, tell us how they spend their money that they get from the Federal level, tell us what are the best practices out there that can serve as models for other States, collect that data.

Right now what we do get is data on numbers of suicides. We get some homicide data, but we really don't get that much on homeless data. We have so-so quality of data for substance abuse, what happens there. But for the most part, no one asks about these agencies and coordinates them. This person's job is to do this. More so, this person is going to have to be a mental health provider, someone who understands the field. The last Director of SAMHSA was an attorney, perhaps well-intended, but did not understand the field. Just like you would not appoint someone to head the Joint Chiefs of Staff to run the Army who is not a general or the Navy who is not an admiral, you need someone to run this who knows what they are doing.

In addition to coordinating these agencies, what they would do is give a report to Congress of which ones can be eliminated because they are redundant, merge the money together, make more money available, and send more money out to communities. Let Congress then act to revamp these multiple organizations to do what is most effective to get funding back to the communities and to the people where it is needed, not to stay in Washington, D.C.

I think President Reagan talked about perhaps some proof of eternity is a Federal program. What we don't want to have here is the continuation of programs that exist just for the sake of employment. Programs should exist for the sake of doing the right thing for people out there, and right now, we have a failure.

The second item is to drive evidence-based care. Another General Accounting Office report which came out talked about some of the abysmal conditions here. They were saying that agencies had difficulty identifying programs supporting individuals with serious mental illness because they didn't always track whether or not such individuals were among those served by the program.

Again, SAMHSA in the past—which is supposed to lead these organizations—doesn't really track to say: What are the evidence-based programs you are doing? When we had a hearing on these issues, SAMHSA told me afterwards they would change nothing.

They do list some evidence-based programs, but the evidence base is oftentimes people who do programs and say: Take my word for it, it works.

If it works, why do we have millions of people with mental illness? Why do we have 4 million people not getting any care at all? Why do we continue to fill our jails, homeless shelters, and morgues with people with mental illness? There are some excellent programs out there, quite frankly, but there are also many that need to be changed.

As part of this process, it was stated in the GAO report that many of the programs hadn't completed their evaluations, many had no evaluations, some were underway, and 17 programs had no evaluation completed and none planned. So the government was not even looking to see if what they were doing had any value. We are going to change that, Madam Speaker. We are going to make sure the programs that are out there have evidence-based care.

The National Child Traumatic Stress Network is an excellent program that does a great job. Another program is called RAISE, Response After Initial Schizophrenia Episode. It does a great job because they work in terms of getting care early in someone's life when they first show symptoms. It is called the prodromal stage. When you get to someone early, you improve their prognosis. But a lot of these other programs—and I will highlight some of the sloppy and irrational programs we have out here tonight—can make a difference if they are done the right way.

Madam Speaker, it is important to note that with regard to serious mental illness, about 50 percent of those with serious mental illness, it will emerge by age 14, and about 75 percent of the cases by age 24. Every time a person has what the public popularly knows as a breakdown, or we refer to it as a psychological or psychiatric crisis, there is harm that occurs to the person, psychological harm and neurological harm, because it is a brain disease. So it is important to get to people early on. That is why we want evidence-based care that really and truly does that and not programs that are fluff. We want them to have outcome measures and determine them.

By the way, Madam Speaker, just the opposite of that, some of the things that SAMHSA has funded in the past have also been programs specifically geared toward telling people to stop taking their medication. When people have anxiety, they have plans in telling you how to drink a fruit smoothie. None of those are evidence-based care, and none of those treat people with serious mental illness.

Number three, go to the mental health workforce. We have a serious, serious shortage here of providers. Even if you wanted to get care, you can't get care in many counties. I think perhaps one-fourth or one-third of counties in Oregon do not even have a psychiatrist in them. Many do not have a clinical psychologist or clinical social workers or peer support teams with the adequacy to meet the need. It is the same across the Nation.

What happens here is there are about 9,000 child psychiatrists in this country. We need 30,000, precisely for the reason I said before, that these problems emerge during those adolescent and young adult years. If you don't have the right qualified people, you can't treat them. Similarly, clinical psychologists, counseling psychologists, clinical social workers, and peer support teams specifically trained and available to be out there, we have massive shortages.

Part of the job of the assistant secretary is going to be to identify what do we need in communities and how do we get them. Our bill authorizes, for the first time, minorities to work with fellowships.

We also authorize people to be volunteers at community health centers. This is one of the bizarre things that only the Federal Government can do. If you want to work at a community health center, you can work, and your medical malpractice insurance is covered. If you want to volunteer, it is not there.

Now, think about this. If there are some well-intended and compassionate—as I know many are—mental health providers who want to volunteer maybe an afternoon a week, give of their time to help, they are not allowed to do it because the center can't afford their malpractice insurance because they would have to pay the regular rate as opposed to a Federal plan rate. Our bill also authorizes that they can volunteer.

We also authorize programs with telemedicine so that when a pediatrician or a family member identifies someone in need of care, they can access them immediately if need be, especially in rural areas and faraway areas where there is not enough support there.

The next one is the shortage of mental health beds. I had mentioned earlier this grave shortage where we had 550,000 beds in the 1950s; we have 40,000 today. It is a serious crisis-level shortage in every community.

During one of our hearings, Senator Creigh Deeds, a State senator in Virginia, testified. Many are familiar with his story. He was a former gubernatorial candidate in Virginia, and he took his son, Gus, with him oftentimes campaigning around the State of Virginia.

Gus played a musical instrument, and they enjoyed their time together; but sadly, Gus deteriorated. When his father, who raised him, fed him, and clothed him, took him to a hospital for care, the hospital said: We don't have any psych beds.

As they made calls and tried to find more in Virginia, they couldn't find any. Young Gus was sent home with his father. They wouldn't provide many details, but they sent Gus home. Gus took a knife and attacked his father, nearly killing him. Creigh escaped, and Gus then killed himself, all because of a lack of beds.

Madam Speaker, there was a story last week in The Washington Post about another Virginia man, a 24-year-old man who was arrested for $5 worth of shoplifting at a 7–Eleven in Virginia. He was taken to jail for shoplifting. But upon recognizing that he had a serious mental illness, they wanted to get him to a hospital. Again, there weren't beds available. So he stayed in that jail, I believe, over 70 days, often naked, covered in his own feces, refusing to eat, and losing 40 pounds. Ultimately, he died for lack of a bed.

Now, that is not the only problem that is out there. Understand that we don't want to bring back those asylums, but when a person is in that crisis mode, it is not appropriate to bring them to a jail.

□ 2045

It is not appropriate to leave them in an emergency room for hours or days or weeks sometimes waiting for a hospital bed to open up, and it certainly is inappropriate to discharge someone without any wraparound services or care.

But what happens is, when you have a bed shortage, you cannot get care for crisis by qualified persons. We don't have the providers. We don't have the places.

It is important for someone to have a clean and calm and caring environment separate from other environmental stresses and problems so you can work with them and stabilize them, perhaps get them on medication, help them relax, help organize things for home care or outpatient care for them. Sometimes that takes a few days. Sometimes that takes a couple weeks. But the idea is you need a place for them.

Without beds, oftentimes a staff simply cannot do a thorough evaluation and they sometimes then will simply make an uninformed and premature release of the individual, of the consumer, saying, ''Well, he doesn't seem that bad. We will send him home,'' not really understanding whether or not that person is a threat to themselves or someone else.

Understand this, that even with the brain diseases of schizophrenia and bipolar, when questioned, someone could be in a position where, when asked if they are going to harm themselves or someone else, they would say, ''No. I am fine. Really, it is okay. It was just a disagreement I had.'' They can keep it together for a little bit.

And if a staff is already saying: Look, we don't have hospital beds. Let's send him home,'' they will be sent home without really knowing the seriousness of their illness or providing full services.

Further, if you want to evaluate if someone is a threat to harm themselves or someone else or in imminent

danger of that, many times the doctors and the courts are reluctant to go through that process. Many times they are looking for another out.

And many times—like in Pennsylvania, it is called a 302 procedure—they will bypass that or they will say to the patient, ''Can you just voluntarily commit yourself or promise you will be okay and you will go out and get care?''

I want to add this because it is very important while the President and other people are talking about access to guns and talking about background checks. You can't do a background check if you don't have a background record—you can't do a background check if you don't have a background record—and if there is no place to help people when they are in crisis.

And if doctors and judges are not going to have someone involuntarily committed, there is no record. There is nothing that can appear on the national list to prevent a person from purchasing a firearm.

There was no time spent in a hospital where staff can truly evaluate are these delusions and hallucinations which can be controlled with medication, will the person be stabilized, are they a risk threat. You can't do that. We need more beds, and our bill says there will be more.

This is one of those areas of incredible prejudices and bigotry. You see, Medicaid has this rule that, if you are between the ages of 21 and 64, you cannot go into a private hospital that has more than 16 beds. Now, think about that.

If you have money, you can go in a hospital. If you are low income, you are out of luck. You are on the street. It is a different standard that is grossly unfair and incredibly prejudicial. And again I go to this point, that those who are minorities or low income are treated the worst.

A person is ten times more likely to be treated in a jail cell than in a hospital if they are seriously mentally ill—ten times more likely. And, yet, that treatment in a jail cell is not appropriate at all.

It is not treatment. Oftentimes they are put in isolation. They may get in a fight with a guard. What started off as a small charge may end up as a felony assault charge.

A person with serious mental illness oftentimes for the same crime will spend four times the amount in jail as a person who is not mentally ill. And all along, if we had the proper place to treat them, we could have done that.

Our bill lifts this 16-bed cap, this ridiculously absurd 16-bed cap, and says, instead, we would like to have an average length of stay of less than 30 days. That can be achieved. In about 98 percent of cases, it can be achieved.

And, by the way, it is far less expensive to have someone in a psychiatric hospital bed than an emergency room by about four times. Some studies have gone as high as saying it is about 20 times less expensive to have them in outpatient care than in a jail cell.

We would save a lot more money if we fixed this crisis shortage, worked on other outpatient care to transition people out, and wrap them around with the necessary services so they could go out more stable.

Point number five: We eliminate the same day doctor barrier, another one of those ridiculously prejudicial rules out there that Medicaid has that harms those of low income.

I mentioned a number of times that the prodromal stages of adolescents and young adulthood is when serious mental illness begins to emerge, those first symptoms that sometimes someone may think is a little bit strange, there is something different about this person. Perhaps their grades are dropping. Perhaps they are not taking care of themselves the way they used to. Perhaps they are withdrawing from relationships and friends.

Those could be early signs of a bigger problem. But it takes, between first symptoms and first professional treatment, on average, 110 weeks, over 2 years, of waiting time between first symptoms, in part, because people are not aware of what to look for in the symptoms, but, in part, because they are not connected with other providers here and, even when they are, they are not allowed to do anything.

The same day doctor rule is a Medicaid rule which says you can't see two doctors in the same day at the same location.

So here is the problem. If a pediatrician says to a mother or father, ''We are very concerned about your teenage son''—who is in the later years, 17 or so—''I would like him to see a psychiatrist right away because I am very concerned about the behaviors you are describing to me'' and then, when that doctor realizes that that person is on Medicaid, basically, Medicaid says, ''We are not paying for it,'' how cruel and abusive is that, to say to someone, ''Just because you have low income we are not going to cover the services here'' when this is a critical time?

When you have that warm hand-off in the doctor's office, there is a 95 percent likelihood that the person will follow up, according to a study by Children's Hospital of Pittsburgh.

When you wait and you say, ''Here is the number. Call it another day,'' that likelihood drops below 45 percent.

And when you miss that golden opportunity to help a person in times of need, that person may be very reluctant to come back for care in the future. We fix this by saying we are going to drop that same day doctor rule.

Number six: We have to empower parents and caregivers to be part of the solution. Twenty years ago HIPAA laws came out that said, ''In order to help your insurance be portable, we want to protect the records.'' Good idea. ''We wanted to make sure records had privacy.'' Good idea.

But HIPAA moved from the place where we are supposed to assist care and confidentiality to the point where it impairs care. It has gone too far. Let me give you a couple of examples.

Right now a doctor—and I am a psychologist. If I know a family member brings someone in to see me, I can listen to them in a very passive mode, but I can't provide them any information. That is helpful. They are giving me vital information for history.

If I don't have the accurate history, a provider does not have accurate history, you can't accurately diagnose. You don't know if the person has been on medication before, does it work or not work, who has this person seen before, what sets them off, are they doing better, what are their symptoms.

If I don't have or a provider does not have that information, they may miss making the accurate diagnosis and then not be able to provide proper treatment and follow-up. When that occurs, harm can follow.

Now, if I get the information, great. But what happens if that family member is not there? The provider can't go out and seek other family members and friends to get that information because HIPAA laws are seen as barriers to that.

Because as soon as a doctor at a hospital calls and says, ''Your adult son is in the hospital. I need to ask you some information about it,'' that doctor has already violated HIPAA laws by identifying the person's son is in a hospital.

Now, think about this, though. A parent, the person who was caring and loving throughout a lifetime, committed to their family member, a brother, a sister, someone's mother or father, they are prohibited from being part of the care team by HIPAA laws.

A stranger, some appointed worker, someone who may see them as they roll in and out of their job, even if they care and they burn out, they will be maybe sitting next to a family member in court and simply say, ''I can't tell you anything about this family member. You will have to find out for yourself.''

Here is another problem, though. Not only are you impaired from getting diagnostic information, you can't evaluate medications. But understand that people with serious mental illness are often at high risk for other medical problems, in part, because their hygiene may be poor, they may not take care of themselves, may not see doctors, et cetera.

But they also are in a situation where they may take some medications that make them high risk for diabetes or heart disease. And without getting a family member to help them with that, they do not have the ability to properly treat them.

My goal in this bill is to simply say that, in cases where someone has diminished capacity to take care of themselves where, in absence of treatment, they become gravely disabled, a provider may tell a known caregiver—so notice I have already set the bar pretty high—may tell a known caregiver a few simple facts: the diagnosis,

the treatment plan, the treating doctors, time and place of appointment, and what are the medications they are on. No therapy notes are allowed to be exchanged. We specifically prohibit that in this bill. But that is important.

And, by the way, I might add one other thing. As I hear a lot of people talking about the concerns of why didn't a parent do anything, why didn't they know anything in some cases, like the young man at Virginia Tech who killed so many students or the gentlemen in Oregon or at Sandy Hook Elementary School in Connecticut, it is because providers cannot do a risk assessment.

They cannot contact a family member and say, ''Can you tell me if this person has any morbid fantasy and fascination with death, with extremely violent video games, with dark Web sites? Do they have weapons that are unsecured? Do they talk about violent issues? Have they made threats before?'' You can't do that risk assessment. Without that, you end up not knowing the risk.

Number seven: States receive money for mental health services and substance abuse disorders. Those dollars are about $500 million for mental health and about $600 to $700 million for substance abuse. The odd thing about this is States are not allowed to mingle that money. They can't braid it together.

Even worse is that many people with a substance abuse disorder have a mental illness and many people with mental illness will turn toward other substances to self-medicate. And, yet, the person will have to go to two different providers, two different clinics, to get care instead of one. We drop that barrier and say Federal grants should go to States in a way that help the States work this best.

Number eight: We want to bring accountability to the spending of Federal funds. Now, here is where we have seen in another GAO report the absolute absurdity and cruelty of how money is spent.

A GAO report done this last summer told us that many times documents and applications for many who receive grants were not reviewed. They couldn't tell you what the application criterion was to get an award. They didn't have program-specific guidance. Information was missing or not readily available. They didn't even know where it was stored. You couldn't follow the paper trail to see where it was. And so what happens is no one knows how this money was spent.

But let me tell you some of the absurd things we have found money is spent on, our tax dollars. How about this? A Web site last winter was posted by SAMHSA for the people of Boston to help them with their worries about snow. That is right. They posted a 1–800 number you could call if you had snow anxiety. These are people from New England, for goodness sake. They know how to handle snow. But our tax dollars went to help them understand it.

There are Web sites that tell you to drink a fruit smoothie if you are anxious, programs that tell you how to make a mask, programs that we fund to how to make collages, a painting in SAMHSA's headquarters that cost $22,500 of two people sitting on a rock surrounded by other people—$22,000.

When we asked the director of SAMHSA what that was for, they said it is more mental health awareness. The only thing I am aware of is it is a waste of money and that money could have gone to help pay someone's salary to actually treat a patient.

Well, it gets worse. A Web site for 3-year-old children, the cost of $426,000, with animated characters and singalong songs. The purpose, we asked the director of SAMHSA, prevention. ''Prevention of what?'', we said. ''Well, we think prevention is good.'' ''Well, what does this prevent and what does it do and does it work and does it do anything?'' We waited for weeks to get an answer and we still don't have it 1 month later. By the way, they took the Web site down when we shined a bright light on it, saying, ''What does this do?''

We want accountability to this spending. There will be different grant programs now—demonstration grants, innovation grants—where people will know what these grants are. They can look at them as scientific studies in a blind review to make sure it is going to quality programs that really make sense. No more of this behavioral wellness stuff, but truly working at things that make a difference.

Number nine: Develop alternatives to institutionalization and have real jail diversion. I said already what happens to so many people with mental illness. They end up in jail. Forty to sixty percent of people in prison have a mental illness.

And what this does is it helps provide some extra funding for States that have wraparound services for those who have this history of violent incarcerations, arrests, mental illness.

□ 2100

New York has a program called Assisted Outpatient Treatment. Their program, which means a judge will say you need to stay in treatment at an outpatient level, has found they reduced incarcerations by 81 percent. They reduced homelessness by over 70 percent. They reduced admissions to emergency rooms by over 70 percent. They had patient satisfaction, consumer satisfaction at over 90 percent. And they cut costs in half.

States have different programs here. About 46 States have something on the books. But many of these States do not put these programs in practice because of the big cost. We know States will save a lot of money once they start doing this.

But what we want to do is take people out of this cycle, this revolving door of jail and risk and more damage, and say that States need to have programs where it wraps around services for that person. Don't just dump them from jail onto the streets and expect a problem because it will erupt again. Make sure those services are there. Make sure the person stays in treatment.

Now some say, well, that is unfair. Some say that might be an involuntary commitment, that it puts people there against their will and you impair their rights.

But I say this, that a person with serious mental illness 40 percent of the time is not even aware they have a problem and so many times they refuse treatment or their past run-ins with the police and other hospitals because they don't want to be there, they don't want to get treatment.

If we provide quality, compassionate, accessible care, they may get that, but not under the current system. We want to make sure they have that care, and we will provide the funding to do it.

Number 10, advance early intervention and prevention programs: A lot of what our government spends money on is what is called primary prevention, the things we do for everybody, like don't smoke, wear a seat belt.

But what happens is, in the area of mental illness, those wellness programs like I described before that are out there, the silly things that SAMHSA does, are not an effective use of dollars.

Secondary and tertiary prevention is valuable. Secondary is when you recognize someone is at risk, but not with symptoms. Tertiary is when they have symptoms and you try and help them get better.

By focusing money on the programs I mentioned before—the RAISE program or others, the Child and Adolescent Traumatic Stress Network—you can move the dollars where they need to be funded and stop this silliness.

Now, I should say this while I am talking about SAMHSA, that despite two GAO reports that criticize them—and one time afterwards I had the director of SAMHSA in my office and I said, ''Okay. Here is your opportunity. Would you change anything?'' And she said, ''No. I wouldn't change a thing.''

Another time during one of our hearings one of my colleagues said, ''On a scale of 1 to 10, how would you rate yourself on your programs?'' And the director said, ''I would give myself a 10,'' despite all these failures.

That is the reason why we need to have an assistant secretary of mental health. That is the reason why we need to make these changes. This is the current reason why we have so many of these problems.

Before I wrap up here, I want to yield a couple of minutes to the gentleman from Pennsylvania (Mr. THOMPSON), who has also been involved in the field of wellness and is also a supporter of this bill.

Mr. THOMPSON of Pennsylvania. Madam Speaker, I thank my colleague from Pennsylvania for yielding and for

leading on this incredibly important issue that is before us.

I rise in support of Congressman MURPHY's bill, H.R. 2646, the Helping Families in Mental Health Crisis Act of 2015. You know this significant piece of legislation aims to address the fact that millions of Americans who suffer from a serious mental illness are going without treatment, as families and caregivers struggle to find support in a disorganized healthcare system.

I practiced rehabilitation services for 28 years before I had the privilege and honor in 2009 to come to work on behalf of the citizens of Pennsylvania's Fifth Congressional District. Part of my career was working acute psychiatric services, working with people that were experiencing some of the most chronic and reoccurring disabling conditions that are out there.

Many times the system that we are in only really responded when people were in crisis, but it only responded to the point that the person was no longer a danger to themselves or someone else.

The system did not allow for the types of resources to be deployed and the care to be provided to really meet the needs of these individuals to stop the cycle.

It was really a privilege and honor to work with many different individuals and many different family members.

But I am so excited about this step that we are taking with this bill, and I really encourage leadership. This is a bill whose time is now. We need to elevate it to the House and to the Senate. This needs to be on the President's desk because we can make a difference in people's lives with this bill.

It is hard to deny the staggering consequences of neglecting our mental health system. Suicide rates are at the highest they have been in more than 25 years. Our nationwide shortage of psychiatric beds is nearly at 100,000. The three largest mental health hospitals in the United States are classified as criminal incarceration facilities, prisons.

I have taken the opportunity—I think it is important—to make visits to our prisons within the congressional district. I have done that. I have more of those visits coming up.

It is very apparent to me that, as we have closed in the past facilities that perhaps we could have improved upon versus closing, all we did was shift people to the streets and from the streets to the prisons.

So many people today have a dual diagnosis, some type of psychiatric diagnosis, but also a substance abuse diagnosis, which tends to be a part of that spiral. And your heart breaks to see that.

If we want to reduce our prison population and the cost that it takes to maintain individuals, then this bill is a good step in that direction of breaking that cycle. I would argue that this bill will help have a cost savings over time, short term and certainly long term.

Congressman MURPHY has taken a compassionate and evidence-based approach to reforming the way the Federal Government addresses mental health.

H.R. 2646 breaks down barriers for families. It encourages innovative models of care. It advances early intervention and prevention programs.

Notably, it employs telepsychiatry to reach underserved and rural population areas where patients have difficulty accessing needed care. I know for a fact using telepsychiatry reduces the stigma of reaching out for help.

I authored a bill that has become law. It is called the STEP law, the Servicemember Telemedicine Electronic Portability Act, which we really did this for our military, our Active-Duty military Reserve and Guard.

We changed the law a few years back with a piece of legislation that has expanded telemedicine that is used by the Department of Defense, and it really has helped save lives. It has not been the only thing we have done, but it was a valuable part in the reduction of the suicide rate among our military.

So we know the many provisions within this bill are tested. They are proven. There are lives to be improved and lives to be saved. It recognizes the important role of the family, the caregiver.

Now, these are some of the most chronic and recurring conditions, and you need a strong support system. The way our system is today, it excludes those family members.

So there is just a lot to support here, and I am certainly proud to do it.

It is important that we make a commitment to address mental health with the same urgency as we do physical health.

I will remain steadfast in my support for H.R. 2646, and I encourage my colleagues to do the same.

Mr. MURPHY of Pennsylvania. In my closing minute, let me say this: As I opened up, this will be known as the bloody summer of 2015. Let this time be the autumn of our compassion in 2015.

The time is now. We have 40 newspapers around this country that have published endorsements for this legislation. We have 133 bipartisan cosponsors.

I plead with my colleagues to please become a cosponsor to this bill. I beg leadership. Let's no longer have a blind eye to this, let's no longer have a moment of silence, and let this be the time of our action.

Let's pass H.R. 2646, the Helping Families in Mental Health Crisis Act, and let's bring compassion and care to the many families in America who are suffering from mental illness and show them that that twilight, as the sun sets, is indicating that there soon will be a dawn of great hope in America.

I yield back the balance of my time.

REPORT ON RESOLUTION PROVIDING FOR CONSIDERATION OF ESTABLISHING A SELECT INVESTIGATIVE PANEL OF THE COMMITTEE ON ENERGY AND COMMERCE

Ms. FOXX (during the Special Order of Mr. MURPHY of Pennsylvania), from the Committee on Rules, submitted a privileged report (Rept. No. 114–288) on the resolution (H. Res. 461) establishing a Select Investigative Panel of the Committee on Energy and Commerce, which was referred to the House Calendar and ordered to be printed.

REPORT ON RESOLUTION PROVIDING FOR CONSIDERATION OF H.R. 3192, HOMEBUYERS ASSISTANCE ACT, AND PROVIDING FOR PROCEEDINGS DURING THE PERIOD FROM OCTOBER 12, 2015, THROUGH OCTOBER 19, 2015

Ms. FOXX (during the Special Order of Mr. MURPHY of Pennsylvania), from the Committee on Rules, submitted a privileged report (Rept. No. 114–289) on the resolution (H. Res. 462) providing for consideration of the bill (H.R. 3192) to provide for a temporary safe harbor from the enforcement of integrated disclosure requirements for mortgage loan transactions under the Real Estate Settlement Procedures Act of 1974 and the Truth in Lending Act, and for other purposes, and providing for proceedings during the period from October 12, 2015, through October 19, 2015, which was referred to the House Calendar and ordered to be printed.

LEAVE OF ABSENCE

By unanimous consent, leave of absence was granted to:

Mr. HUDSON (at the request of Mr. MCCARTHY) for today and October 7 on account of family reasons.

ENROLLED BILL SIGNED

Karen L. Haas, Clerk of the House, reported and found truly enrolled a bill of the House of the following title, which was thereupon signed by the Speaker:

H.R. 2835. An act to actively recruit members of the Armed Forces who are separating from military service to serve as Customs and Border Protection officers.

BILL PRESENTED TO THE PRESIDENT

Karen L. Haas, Clerk of the House, reported that on October 5, 2015, she presented to the President of the United States, for his approval, the following bill:

H.R. 1624. To amend title I of the Patient Protection and Affordable Care Act and title XXVII of the Public Health Service Act to revise the definition of small employer.

ADJOURNMENT

Mr. MURPHY of Pennsylvania. Madam Speaker, I move that the House do now adjourn.