Chairman Pitts and Ranking Member Pallone,

Thank you for inviting me to speak to you today. My name is Dr. Michael Welner. I am a psychiatrist and forensic psychiatrist. I come to you to encourage you to vote to pass HR 3717 to a vote for the full house.

HR 3717 t is important to you as your own constituents, as fathers, mothers, and grandmothers who may one day interact with a person like myself for reasons that are your worst nightmare, worse than something concrete like heart disease, who might one day confront the inscrutability of your own mental infirmity at the boundaries of the skills available to you, who might have a son like Representative Creigh Deeds whom you cannot save, who might be the only support for an autistic child, who might be at the boundaries of a loved one who refuses help, where medication no longer helps, or where the therapy advances are 300 miles away.

I was originally asked by the Energy and Commerce Subcommittee on Oversight and Investigations to participate in a mental health reform panel convened last March on lessons from Newtown in my capacity as Chairman of The Forensic Panel. In my practice, we scrutinize the criminal who survived his shooting rampage, the hospital being sued for negligence for discharging someone who commits suicide, the mother who kills her five children days after her medication dose is lowered, the head injured Iraq veteran who blows up his commanding officer, the sex offender who everyone knows will offend and does. We see the messes of bigger problems from all over the U.S. before they become discussions in Congress.

I have studied Helping Families in Mental Health Crisis Act with this inspiration in mind:

What is the nature of a mental health **crisis**, and what are the consequences of that **crisis**?

Who is in a mental health crisis?

When is there a particular risk of crisis?

Why is a particular crisis happening more frequently than it should?

How is a particular crisis to be solved?

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What is the nature of a mental health crisis, and what are the consequences of that crisis??

Contemplated violence. Unfettered impulsivity. Destructive command hallucinations. Suicidal urges. Explosive abuse. Descending chemical dependency. Neglect of the vulnerable child.

Every crisis is different and requires proactive intervention to prevent tragedy. This is what distinguishes crisis in any aspect of medicine and in society.

Wherein the law would currently define a mental health crisis as **danger to self or others**, that word *danger* bedevils the decision maker and damns the family in the mental health crisis. If it's your family, and someone is considering violence on their own timetable, the law says it's currently not immediate enough to intervene. I've examined six mass killers; when they decide they are going to be dangerous, it's too late for you to stop them because they will make sure the doctors never know.

If it's your family, and your sister is a battered woman, you know that Impulsivity and explosive abuse doesn't have to happen every day or every month.

If it's your family, you aren't hearing what the voices say, and if you are hearing voices, chances are they relate to your family. What then, if they are your frightening and irrational secrets?

Suicidal urges may come and go, or come and come. Now, what if you are the child of a suicidal parent? Or spouse and fellow parent?

In any one of the above, something may be happening that creates neglect of the vulnerable child. Long before I examined Andrea Yates, she knew she was neglecting her children and then killed them as a solution to her own incompetence. While she was receiving exemplary mental health care. And no one speaks for the children.

The Helping Families in Mental Health Crisis Act embeds the notion of danger in the real world of **what is a crisis**. Not "danger to self or others," or "imminent danger" which right now is a barrier getting in the way of admission, program eligibility, continued care, and access to services. Rather, HR 3717 focuses on directing services to crisis situations designated as "may be dangerous to self or others, unwilling to undergo treatment, may be unable to provide for basic needs, including safety, or a condition which if not timely treated, is likely to substantially deteriorate," which invariably bear consequences and risk to those who are in crisis and to their families.

This is wording that is meant to prevent cracks from allowing even the best of intentions to miss the person who is in crisis from crawling in. This extremely important change is not meant to encroach on personal liberties and doctors and families are not inclined to do that anyway because whenever you bring care or commitment to someone who is mentally suffering, you are on the front line and it is you who get their anger, abuse, and venom. Those who care are willing to endure that. But right now the law does not allow caregivers to get help for people in crisis.

Who is in mental health crisis?

It is that person in the above mental health crisis who denies there is a problem. And the family cannot get through that denial.

It is that mental health crisis involving a person who does not fall in the cracks, but crawls into the cracks because the person does not want treatment, from any mental health professional

It is that person whose coping qualities are so immature that decisions coming are doomed to create risk to self or to others

It is that person who feels isolated in their hopelessness, because their issues go beyond a chemical imbalance

It is that person who is hopeless and desperate, diagnosis or not.

The Helping Families in Mental Health Crisis Act:

- Funds the expansion of Assisted Outpatient Treatment. In so doing, HR 3717 enables treatment to reach those in crisis and to whom it must but otherwise would not
- Funds expansion of cooperative efforts with law enforcement to recognize mental health crisis and to enhance crisis intervention
- Develops cooperative efforts with corrections settings to provide mental health services to inmates whose crisis leads to incarceration and elevates risk for continued reoffending and victimization of others

When is there a particular risk of crisis?

It may be hard to tell. No one knows the person in crisis like responsible and close caregivers and family. A doctor sees a person, if at all, for only an appointment. And the seriousness of a situation can be overlooked by a doctor when the person in crisis is in denial or is misleading the impression of the doctor or therapist.

HIPPAA laws currently are used as barriers preventing doctors and caregivers from getting information from (and even to) caregivers at critical times; and, from involving families in crisis treatment planning. Educating health care providers about what allowances HIPAA now gives for disclosure would not solve the problem; it is easier for doctors not to breach their privacy with their patient, and so they do not. A patient can easily assure a doctor that no imminent risk to any identifiable person is present in order to keep caregivers from exposing high risk activity.

The Helping Families in Mental Health Crisis Act facilitates communications between families and caregivers during time of crisis, “in order to protect the health, safety, and welfare of one or more individuals.” A broader definition of public safety gives doctors more of a stake in protecting others from a patient at risk, and enables caregivers to have necessary access in times of crisis.

Why is a particular crisis happening more frequently than it should?

Mental health is no different from other medical specialties – an exploding knowledge base creates important subspecialty niches to better focus care. What one trains in to master child psychiatry is very different from what one needs to master for substance abuse psychiatry, which is far different from what one would need to know for crisis intervention, or psychotherapy with the chronically suicidal. There are many areas of the country with few subspecialty-trained mental health professionals to meet

the population needs. Community mental health centers are sorely understaffed with those with subspecialty expertise.

Knowledge of the brain and subspecialty research discoveries have matured the behavioral sciences. Yet unlike any other medical specialty, the administration of mental health resources is heavily influenced by substance abuse treatment models that are often antagonistic to medication compliance and psychiatrists as external influences on patient care. Would the national health system have holistic medicine control the budget for medicine and surgery? Of course not. Would any other specialty submit to having its budgeting controlled by leadership that ideologically rejects medical intervention and embodies denial of illness?

Think about it. Let's say such a movement existed to stop taking anticholesterol medicines as harmful, opting for control of the food supply to eliminate certain aspects of the foodstuff. Noble goals, perhaps, but would we have such an organization with such goals administer the budget for medical care and research and hospital medicine? Would you in Congress allow for physical therapist organizations to control the budget allocations for surgery disciplines? Of course not. The behavioral sciences and its administration cannot be a subspecialty working at cross purposes with itself. So, why are the resources for mental health so controlled by forces whose ideology is overtly antagonistic to staples of psychiatric treatment?

Reimbursement remains disproportionately poor to medication treatment. As a result, psychotherapy, which may be the best treatment option in a given crisis, withers and cannot be found when needed.

The sickest patients may need the most services. Yet those who make themselves available for the hardest to treat and those most likely in crisis are reimbursed the least.

Closing of hospitals and reducing beds is a direct byproduct of mistaken short-shrifting of the acutely ill and at risk.

In order to make the treatment of those in crisis, be they children, the repeatedly violent, those with stubborn drug addiction, those post-incarceration or with compliance problems, we need to make crisis psychiatry a growth industry. The hardest patients deserve the best and brightest.

Liability risks deter psychiatrists from crisis patients just as obstetricians shuttered their high risk practices and neurosurgeons did theirs. Honesty about what crisis is – and what it entails – demonstrates why litigation risk drives the best and brightest away from a calling to help those in need. Risk is native to crisis management. I know, I started my career treating the repeatedly violent. I know what it's like to have a patient attack his dad in front of me at 10 PM in response to hallucinations – with no security down the hall for me to call. I also know what it's like to have a patient who tells me he has killed before to test the therapy. So why aren't those who have the courage to manage those in crisis protected like emergency responders and police officers?

The Helping Families in Mental Health Crisis Act:

- Ensures that mental health funds are allocated to those programs promoting mental health care and compliance with care, not experimental models rejecting treatment and promoting denial of illness.
- Fulfilling staffing needs for the necessary range of subspecialty expertise to otherwise underserved areas for both medication and psychotherapy expertise, specifically child and adolescent psychiatry, crisis prevention, treatment of violence, dual diagnosis issues
- Ensures access to vital medications by codifying a requirement that Medicare and Medicaid offer all, or substantially all, antidepressants and antipsychotic medications
- Providing a range of crisis management and stabilization services to underserved areas
- Explores changes in reimbursement to promote treatment of the underserved and those in crisis and those needing more services, and incentives for demonstrated quality of care
- Promotes liability protection for those giving of themselves to underserved areas

How is a particular crisis to be solved?

Mental health resources need to be dedicated to a mission that respects all aspects of treatment, including medication, psychotherapy, and hospitalization, as essentials of mental health crisis management.

Collaborative mental health care models must be implemented so psychiatry can be complemented by crisis intervention skills and resources of law enforcement, corrections, schools, and houses of worship – each available to engage families in crisis.

Promote psychiatry as a science and public resource. If psychiatry is stigmatized, its patients are stigmatized. If we want to diminish denial of illness, we need to destigmatize psychiatry as a diagnostic and treatment source. It is no different from public service. When the dignity of public service is debased, those served no longer respect the institutions.

Do not let the illness drive the treatment. Denial is not to be confused with determination to overcome. Denial has no place in medicine. Denial has no role in crisis management.

The Helping Families in Mental Health Crisis Act of 2013:

- Consolidates resources in a structure of a National Mental Health Policy Laboratory, whose mission requires the seamless integration of biological and psychotherapeutic treatments to promote established treatments for mental illness and substance abuse, reduce mortality, and advance rehabilitation
- Identifies and pursues research initiatives with the above scientific inspiration in mind and integrating the National Institute of Mental Health, the justice system, corrections, and law enforcement in policy planning with mental health consumers and families, and end user practitioners
- Promotes education about the potentials and progress of mental health care

- Operationalizes multidisciplinary models for mental health intervention in underserved environments, linking mental health centers, families, psychosocial supports, the justice system, religious organizations, and law enforcement
- Promotes mental health assessment and response training of corrections, law enforcement professionals and first responders

I have treated patients for twenty years, and have been board certified in forensic psychiatry, psychiatry, disaster medicine, and psychopharmacology. The latter is notable here. Congressman Murphy is a psychologist. I am proud of the medications I prescribe, proudest when I tell a patient I am discontinuing your medicine because you don't need it or me. I also recognize the psychotherapists, social workers, and counselors who make a difference when medicines are not the answer or not the full answer.

And I too am a psychiatry constituent. I tried in vain to commit my psychotic sister who had no lesser right to a great life than I have, but she was one of those people who, no matter what she did, was never a danger to herself or others. She ultimately became the woman I buried at age 32. My last letter from her before she disappeared, only to be found six months later, was to thank me for how I spoke about her when I had her committed. I learned as you indeed will that when the illness runs the care and the situation, the care is psychotic and may be suicidal as well. No matter who you are or who you know.

I am the responsible provider for another family member with serious mental illness. He is adamant that there is nothing wrong. He is dependent upon me financially – flexibly accommodated at our office, in fact, in exchange for agreeing to take his antipsychotic, going to the gym, staying on the diet his naturopath made for him and practicing guitar. He would crawl into the cracks otherwise. In therapy, he runs the message. And when he falls apart because he cannot tolerate certain stresses of interpreting the rational world, his therapist does not allow for a line of communication. When things go wrong, I'm the first to see and the last to know what is happening. He is the first to know what is happening and the last to say anything or to know what to do, but I am expected to pick up the pieces when he falls and to protect him. I'm all he's got. And like many parents, grandparents, and other relatives in the same position, I likely care more about his rights than he does.

My heart breaks for him. He is highly educated and sweet and gentle. He never did anything to invite the onset of his condition. I wish I could take away his illness. But denying his illness does me no more good than were I to deny lupus or any condition one is better off living with by treating with psychiatry as a partner.

I will not bury another. Nor should any of those families whose loved ones' autopsy reports follow me every day as a forensic psychiatrist. We are here not because of their loss, but because the Lanza tragedy demonstrated how crisis does not always stay in the family.

Our imperative is Helping Families in Mental Health Crisis. Thank you and may God bless you to take up the people's business with the decisiveness with which crisis management must transcend self-interest that would sacrifice the national good. And may God bless you with a mental health system that you have built to respond when crisis finds you as well.