Responses to Queries of Subcommittee on Health
Re: H.R. 3717 Helping Families in Mental Health Crisis Act

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Chairman, The Forensic Panel
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The Honorable Joseph R. Pitts

1. ***In your opinion, how has the legacy of deinstitutionalizing the mentally ill worked out over the past half-century?***

Let's remember that when we speak of "de-institutionalization," we speak of what we NOW think of as long term psychiatric hospitals. When they were originally developed, mental institutions as they were known catered to our society at an age in which psychiatry was far less invested in its science for those with serious and chronic mental illness. The role of mental institutions was custodial and at a time when those with chronic mental illness were as dehumanized as others were prejudiced.

In such an age of low oversight and the perception of chronic and seriously mentally ill as essentially hopeless cases (or at least, irrelevant to broader society), a more primitive psychiatry was treating with high doses of sedating antipsychotics like Thorazine, other sedating agents, or even lobotomy. Devaluing becomes conditioned as hopelessness begets abuses. And so custodial and experimental care were eventually exposed for their appalling inadequacy and lack of humanity. We must remember that this was the catalytic force of deinstitutionalization, not medical economics. But unanticipated progress followed, just as psychiatry was fleeing the institution model of care for the seriously mentally ill, primarily for how it stigmatized psychiatry.

Quantum leaps in psychiatric therapeutics have paralleled the exceptional civil rights sensitivity of contemporary America. Moreover, psychiatry has become ever more scrupulous about its scientific methodology, beginning with diagnosis and the DSM and continuing to therapeutics. Whereas therapeutic options and advances were substantial in the 1980s and 1990s, options still remained more limited. Now, a range of therapies from transcranial stimulation to light therapy to EMDR to genetics to omega-3 to naturopathic interventions are providing a broad range of therapeutic approaches to better defined chronic mental illnesses.

Therefore, it is my professional opinion is that we are not confronting a question of, "What is the impact of deinstitutionalization," but rather a more urgent query, "What is the impact of psychiatry's advances now that institutions are no longer available?"

The impact has been huge. Because those who were institutionalized who were released because those facilities closed were never discharged because they were treated or healed, they were essentially evicted from where they otherwise needed to be, as if a renter were to be moved out by a condo developer. Those who languished in institutions under over-sedation or psychosurgery were given desperate and non-specific treatments, because that was all that was available. But they still needed treatment desperately in the first place that could not be provided to them in the community because of the dire nature of their illness. Those who were abused in mental institutions still belonged in institutions – they were mistreated, or neglected instead of being cared for the fragile and fractured minds they truly were.

And those who did not belong in institutions were not there because of 2014 psychiatric assessment skills, along with current hospital oversights, even the combination of those skills with unscrupulous families who committed them to settle scores. No. they were misunderstood because the psychiatry up to the 1970s really was adolescent compared to today. Ours is a far more rigorous science than ever before.

Unfortunately, the advent of demonstrably helpful solutions for serious mental illness – more effective, more tolerated, safer medicines that have impact on broader ranges of symptoms – coincides with deinstitutionalization. Thus, even with the tools to treat the people who were once appropriately committed and without hope, deinstitutionalization had created conditions in which a lack of access of beds, a lack of sufficient hospital days, and restrictive formularies compromise treatment.

For comparison purposes, let us consider a surgical hospital that diverted a number of procedures to ambulatory care. There are still core surgical procedures that require inpatient stays. And there are still complex surgical procedures that require lengthy hospitalizations. Psychiatry and serious mental illness is no different. Nor should the mandate that each psychiatrist embraces be different. No surgeon would send a patient home at high risk for complication, relapse, and medical calamity. No psychiatrist would rightfully wish to either. Yet in the current climate of deinstitutionalization, this is exactly what happens from hospitals and emergency rooms, with obvious impact.

For those who serious mental illness impacts or is accompanied by an unwillingness to get help, their deterioration is inevitable and tragic. Their destiny may be

1) In what has become one of the largest psychiatric hospitals in any area, the local jail or prison. It is telling and damning that only since deinstitutionalization have prisons

become overwhelmed by mental health needs. What was anticipated to be a cost-saving measure is now the problem of those seeking to relive overcrowded prisons.

What was a civil rights triumph for those who fought hospitalization and commitment is now the bitter pill of criminalized mental illness. Bad as hospitals once were, jails are worse – especially jails overburdened and overcrowded with those with special mental health needs. Bad as institutionalization was, psychiatric hospitals now are better than many residential situations, let alone jail.

2) Custody of overwhelmed families in hostile, dependent relationships in which little therapeutic benefit exists beyond material support. These situations are known for their violent outcomes, however uncommon the incidence of violence in the mentally ill.

3) Homelessness. My work on a murder case involving a homeless man with serious and chronic mental illness on Hawaii's Big Island exposed me to the little known local knowledge that the expanse, laid back mentality of the community, ability to hide as a paranoid individual, and the reliably temperate climate were responsible for attracting large numbers of homeless mentally ill from numerous states to Hawaii. Is that a mental health policy to serve the needs of the seriously mentally ill?

Psychiatric specialists no longer relate to chronic mental illness as hopeless and dehumanized, inscrutable puzzles to be treated in a safe and controlled environment. Treatment options are that good and helpful, really, to that level of frequency. All illnesses of those without intellectual deficiency are expected to improve to a degree that a person with even serious mental illness ought to be able to work toward as much quality of life, with as much life , as possible.

But first someone has to get well. Like the complex surgical patient, it may happen, but the treatments take time to generate healing, are not guaranteed to work, may require multiple interventions over time, and monitoring for complications. Without the wherewithal for psychiatric institutionalization, people who genuinely and definitely need are just not getting the treatment that work and the treatments that can save their lives from the many paths of quiet or not-so-quiet ruin. Psychiatric hospitals work and are essential for the patients committed to their long-term care.

2) The Wall Street Journal wrote an editorial this month that raised some concerning issues about SAMHSA's effort to address serious mental illness. Will

you discuss what the federal government can do to improve the mental health delivery system, such as using more evidence-based care models?

The most important change is actually ideological. Serious mental illness needs to be taken seriously. **The time has come to engage serious mental illness as if it is cancer and crisis psychiatry as if it is a medical emergency**. Approaching serious mental illness and crisis psychiatry any differently enables denial to perpetuate the morbidity to the individual and impact on every one of his or her dependents and orbit.

Those who disagree are in intellectual or personal denial. Is that any different from those with cancer or a medical emergency who have the same reasons for denial? The federal government does not have the same luxury, or we would not be engaged in these proceedings.

Unless government begins with this simple ideological change among its mental health leadership, service delivery to those with serious illness and in crisis will be inefficient, reflect poor prioritization, strangled by political correctness, outdated, unable to respond to new challenges such as disasters or dynamic research progress, and handicapped from thinking creatively to solve problems quickly while longer term solutions are being gradually put into place.

Engaging serious mental illness and crisis psychiatry with urgency will infuse a necessary rigor into the study, treatment, and quality control of conditions and situations. Leadership that does not suffer foolishness, ineptitude, poor performance, and non-science gladly will be the best thing those with serious mental illness could ever hope for.

Moreover, it actually is the most important leadership ingredient to serious regard for the civil rights of the individual and public safety. Petty battles over fighting commitment so that a released person, or one not admitted to AOT, can ultimately be incarcerated the next time they become a nuisance, or in a morgue when attacked by bored marauding adolescents who encounter them homeless, needs leadership that treats those with serious mental illness as people who matter but have diseases of insight that are eminently treatable. A society that decides that it need not mingle gun debate to fix crisis psychiatry can finally admit that outpatient commitment would have prevented Adam Lanza's destruction, and that such leadership would have prevented the political correctness that enabled Nidal Hassan and the terrorism of a person on the edge.

Government also has to decide that it is committed to psychiatry as a treating medical discipline. The recent editorial in the *Wall Street Journal*, "***The Definition of Insanity***" spoke of the problem of a SAMSHA budget that has so many resources allocated to experimental and unproven approaches. It highlights allocations to self-help programs that renounce established treatment and are inherently anti-psychiatry, and in the process neglect serious treatment of serious illness in favor of approaches better reserved for minor conditions.

With that said, this editorial only alluded to the bigger problem: that the anti-psychiatry of some sectors of SAMSHA's emphasis, the allocations to experimental programs suited to those with minor emotional problems, or to programs that essentially promote the renunciation of treatment reflect a leadership philosophy promoting denial of the seriousness of serious mental illness, and the urgency of crisis psychiatry. It is the definition of insanity to have such an important national imperative presided over by leadership that actively pretends such problems do not exist or are not that serious.

Denial allows serious mental illness to drive the disease and to drive the crisis. It abdicates leadership not to individual rights, but to a serious illness. Those who disagree do not believe serious mental illness to be that serious. In the case of drug and alcohol addiction, and of serious mental illness, the illness itself is an ingredient of denial.

Those who manage urgency incompetently are unfit to lead. Those who refuse to acknowledge urgency are unfit to have such responsibilities in the first place.

We will make no progress in the delivery of services to the seriously mentally ill until we repudiate its denial with the same determination that one must show to cancer, HIV, and to drug addiction. Those illnesses have demonstrated to us that placating the "oncology consumer," "infectious disease consumer," "illicit substance user" inevitable imperil the very person we are trying to respect, after dragging those around him down first.

Some of the loudest discussions against HR 3717 have been led or instigated by those who consider themselves survivors of psychiatric care. Their personal stories and those of the clients they represent, as attorneys, may be wholly correct and contribute to their denial of the legitimacy of psychiatry as a treating medical discipline. But to transform their disappointments into mental health budget and program decision making is no different from empowering those who suffer surgical malpractice and are therefore opposed to invasive medicine to control the budget allocated to surgical medicine in America. It *is* insanity. These experiences neither generalize nor define the medical discipline. Rather, they

are a byproduct of bad treatment decision-making, which is precisely what funding evidence-based treatment prevents.

Once the appropriate leadership is presiding over the budget allocated to treating those with serious illness, there are other necessary measures. **One critical step is to act on the current reality that many in need deny their illness and would not participate in treatment even if it were available to them with every convenience attached and every cost to them eliminated**.

Current American challenges in the treatment of serious mental illness and those in mental health crisis include many such individuals in denial. To then turn away and to pretend that such individuals are not part of crisis mental health reform because of civil rights is denial.

Yes, illness is real, and you're sick and need to get help! Denial is not only personally risky, but in responsible others, it is expedient cowardice. Public policy must reckon with the fact, as we do as physicians, that placating people's sensitivities about their illness in the practice setting, whether it is cancer, HIV, emphysema, drug abuse, or any other serious condition, enables denial. The patient goes down the drain. It is no different in the legislative arena.

Approaches to such individuals MUST integrate law enforcement, corrections, schools, employers, families, civic organizations, and houses of worship as necessary partners of mental health and force multipliers. Consider, for example, how many lay volunteers, as young as teenagers, have saved lives on telephone suicide hotlines. Mental health delivery is at its most effective when it thinks beyond itself. A leadership that embraces urgency rather than denial must reach beyond mental health to implement mental health.

The consequence of untreated serious mental illness is enormous to the individual and to families and dependents. In the cases of suicide, with its frightening commonality, the material costs are huge. The costs of neglected mental health crisis may involve violence. And in exceptional cases, the community violence is so substantial that it rivals those of terrorist acts.

With that said, **delivery of services will be enhanced by attracting the best and brightest to crisis psychiatry and to treatment of the seriously mentally ill**. The discussions of HR 3717 are borne of recognition that there are not only huge numbers of underserved individuals, but shortages of qualified child adolescent psychologists, psychiatrists, physician assistants and other professionals with crisis intervention training, cultural literacy, substance abuse, psychotherapy and counseling training. A leadership vision

that approaches this challenge will create growth opportunities that attract the best people, the wisest physicians, the cleverest ex-military, the most civic minded outplaced employees, the most sophisticated civil libertarians, and the most idealistic recent graduates to psychiatry careers.

Leadership that radiates the national importance and prestige of such service will not only draw talent that in turn infuses creativity and results, and enhances community mental health and public safety. It will also eliminate stigma of mental illness and promote accessing mental health services through the more conventional channels. Those who see the best of Americans involved in mental health service provision will be drawn to it. Mental health leadership has to create conditions that inspire people to develop and dedicate professional lives to treating the seriously mentally ill and those in mental health crisis. It can and must be done.

3. ***Given your professional work treating individuals with serious mental illness, are the modifications to HIPAA in H.R. 3717, as described by Mental Health America, an "erosion of privacy protections" or "disrupting [to] the patient-provider relationship" in any way?***

Mental Health America, in its published policy statements, **supports** exceptions to the confidentiality of HIPAA in a number of detailed scenarios that include entire classes of patients. They do not qualify that these exceptions are an erosion of privacy protections. Rather, Mental Health America's positions concede that special situations arise that ought to allow for exceptional contact.

HR 3717's modifications of HIPAA are carefully circumscribed in its language. These focus on extraordinary clinical situations in which the patient's welfare or that of others is at stake, and open communication only to those family or caregivers. By comparison, HR 3717's modifications cannot be an erosion if they extraordinary circumstances they address are far more precise than the broad scenarios for which Mental health America already supports even less specific disclosure.

Consider that only a partial list of the exceptions to HIPAA proposed by Mental Health America includes:

1) **Minors**. Children and adolescents are also people with individual rights. Adolescents in particular are often of the assessment that they possess adult judgment and prefer to

make decisions without the knowledge of adults. Said adolescents may be particularly intelligent, even in the face of serious mental illness and mental health crisis. Mental Health America supports exceptions to HIPAA with the treatment of children and adolescents. In practice, this would include the following such patient:

In an existing treatment relationship with a 17 year old, who may even be in college or drive alone to an appointment, the provider can reach out to parents and caregivers for reasons that are not restricted by the recommended Mental Health America exception in any way.

A HIPAA exemption for all children and minors is far less specific than the precise allowances of personal risk and deterioration and public safety that are denoted in HR 3717. It is inherently contradictory for Mental Health America to be comfortable with carve outs to HIPAA based entirely on age and to deem those allowances to HIPAA proposed in HR 3717 to be an erosion of privacy protections. HR 3717 respects privacy provisions of HIPAA and bases its exceptions not on age, but on a level of clinical deterioration that endangers personal or public safety.

Furthermore, the exclusions of HR 3717 involve someone whose judgment is impaired by virtue of their serious mental illness and mental health crisis. It is the appreciation that adolescents, whatever their education and maturity, may lack judgment in such circumstances to warrant a psychiatrist or psychologist's initiative to convey sensitive information to a caregiver or parent. To suggest that a person with serious mental illness or in mental health crisis is any less limited is contradictory.

Treatment providers, when working with adolescents, recognize that even though they are able to communicate information from the treatment to parents and caregivers, the patient may feel betrayed if they do. The caregiver therefore weighs the exception to blanket confidentiality and considers the benefits to the patient, any potential safety conditions, and the risks of the patient's response. Thus, the provider has the latitude to exercise professional judgment, and the patient-provider relationship proceeds or it does not, from the outset. Mental Health America supports this.

2) **Medical emergencies**. According to currently distributed Mental Health America position papers, "Information should be available to health care personnel for the purpose of treating a condition that poses an immediate threat to the health of the consumer or others."

Thus, Mental Health America does not feel it to be an "erosion of privacy protections" when a psychiatrist or psychologist conveys sensitive information of even an adult patient that helps them treat a condition that immediately threatens the health of the patient or others. That could be said of any stage of an acute mental health crisis, of a clearly deteriorating mental health condition, and of intractable drug and alcohol abuse.

Moreover, Mental Health America is comfortable with this exception even though the wording allows that the medical emergency need not necessarily be life threatening. Or, the illness may involve a completely different person.

Moreover, the allowance to the health of that different person does not even specify that said "others" are at risk of actions of the patient, such as an intimate unaware of a partner's HIV positivity.

Communicating a patient's private details in medical urgencies of the patient or others (who might even be estranged from the patient) implicitly means that the doctor is conveying information that the patient himself would not. Many patients would find that disruptive to the doctor-patient relationship. But Mental Health America supports such an allowance. In so doing, the organization recognizes that the physician or psychologist does not wish to disrupt the doctor-patient relationship, and it is prudent to rely upon the physician to act with responsible discretion.

HR 3717 restricts communication to caregivers. Even within family, therefore, the flow of information is restricted. In addition, HR 3717 places the responsibility on the physician to weigh the necessity of conveying information, what that information should be restricted to, how to express those details, and who exactly needs to know. The physician can therefore respect privacy laws, attend to medical risk, and demonstrate to the patient that this provider is trying to protect the provider-patient relationship.

In short, Mental Health America's exemption for HIPAA privacy on "medical emergency" is broader than the more restrictive allowances proposed by HR 3717.

One cannot have a provider-patient relationship without a patient. Serious mental illness and mental health crisis may introduce situations in which a clinician faces that dilemma, and the solution is to communicate with a caregiver. HR 3717's modifications allow for psychiatric treatment to make this natural adaptation to reality and to responsible crisis management.

Consumers who are Legally Incompetent - Mental Health America's position papers allow that a patient may become legally incompetent and in such a situation, a legal guardian should be appointed to make such decisions concerning the release of confidential information. Many seriously mentally ill who suffer a deterioration of their condition become legally incompetent. Legal incompetence may also be the fate of a person in mental health crisis.

The same Mental Health America would allow for a provider to convey information of a minor without asking that a guardianship proceeding. Its position for the legally incompetent is therefore inconsistent.

The confrontation inherent to the process of the appointment of a guardian is disruptive to the doctor-patient relationship. The process requires that the doctors emphasize the patient's weaknesses and debilities in writing and in testimony to secure such a guardian. It asks that the court impose a decision-maker on a patient. The process may be necessary and I know it well, but it is certainly denigrating to the patient by design.

Furthermore, the process of guardianship appointment is lengthy and time necessarily consuming. In the crisis situation, or that of a person's acute deterioration, a person could be cold and buried by the time court approval is secured. But Mental Health America is comfortable supporting this position.

HR 3717 exceptions to HIPAA do not warrant a process that forces the doctor to diminish his own patient. No outside third party beyond the caregiver or family is involved. There is no judge, no proceeding, and no attorneys. Exceptions to HIPAA are restricted to private communications channels between supporting family and doctor. This is far less an erosion of privacy that what Mental Health America already supports, and likewise less damaging to the doctor-patient relationship.

Child and Elder Abuse and Neglect – as Mental Health America points out in its position papers, all states require the reporting of child abuse and neglect. Many persons with serious mental illness or in mental health crisis have children in their custodial responsibility who are obviously imperiled by neglect alone.

If the law requires reporting of child neglect to the authorities, is it not far less an erosion of privacy to engage concerned caregivers or family allied with the patient to arrange for provisions and the welfare of children who may be neglected or otherwise

mistreated (as proscribed by HR 3717) before authorities are NECESSARILY brought in to turn a home upside down?

As such, Mental Health America supports an allowance that is far more of an erosion of privacy and a disruption of the provider patient relationship than what is proposed by HR 3717.

As a psychiatrist who conducted the most extensive interviews with Andrea Yates, the Texas mother who drowned her children, I would recount her recorded admissions to me that even as she was in psychiatric treatment, she was quite aware that she was neglecting her children. This, she explained was at the heart of her decision to kill them; for as her deteriorated if docile condition advanced, and the neglect persisted, and her children became more disruptive and unresponsive to her, she lost confidence in ever restoring their obedience. It was then that she contemplated and then planned to murder them for two months before finally doing so when she had the first opportunity to be alone with them.

The Yates tragedy well illustrates how there are those who are acutely ill who do not obviously demonstrate how imminent their potential risk is, but are sick enough that the neglect of their children is obvious. Mental Health America supports telling the authorities. HR 3717 creates allowance for the provider to decide to communicate with caregivers or intimate family as necessary when serious mental illness demonstrates crisis and deteriorating conditions.

A psychiatrist educated about the respect afforded his clinical judgment under such circumstances would be in a position to save the children in the Yates home and victims of other filicides before being mandated to report overt abuse – which the parent would be invested in concealing. Filicides continue, most recently in Rep. Murphy's Pittsburgh, among those in psychiatric treatment, even when the treatment is available and they participate. Families are unaware of provisions needed to protect defenseless children until it is too late. No one speaks for defenseless children, and they are not here to advocate. But it is they who are killed.

HR 3717 allows the provider to make responsible decisions about disclosure and to use professional standing to mitigate family risk without obliterating family integrity. As in the case of medical emergency, you need a patient for a patient provider relationship. A patient arrested or merely the subject of a child welfare investigation experiences far more erosion of privacy and disruption to the provider-patient relationship.

For the patient who has been violent or suicidal, or in any way is at risk to be violent or suicidal, if that person comes to a mental health professional for help, responsible psychological practice is to protect that person from making irreversible and destructive choices. If that involves engaging a support system at the appropriate time, and if our licensing entrusts a provider to act responsibly just as does the patient who chooses that provider in the first place, there is neither erosion nor enduring disruption.

Allowing professionals to use their judgment allows professionals to be human in weighing the risk/benefit of disclosure. It recognizes that as all physicians take the Hippocratic oath, we all vow to do no harm and to not share information that, as the Oath proscribes, "ought not" be communicated. We psychiatrists know that and live that.

But "ought not" is not synonymous with "will not." "Ought not" also means that when information "ought" to be conveyed to responsible family and caregivers, to not do so is a moral violation.

The outrage that this committee has heard from parents such as Mr. Earley and Mr. Milam is not an anti-psychiatry sentiment. On the contrary, they sought out psychiatry. Theirs is the pain of being on the wrong end of that moral betrayal of caregivers shut out from information that would have saved a life or almost caused loss of another. Their stories, in my professional experience, are not just common, they are widespread. This has to change, and can change with modifications to HIPAA such as those proposed in HR 3717.

4. ***As a treating professional is knowing that you may share information with a family member of that individual if you '"reasonably believe it is necessary … in order to protect the health, safety, or welfare of such individual or the safety of one or more individuals" likely to help in that individual's treatment and recovery, or hurt their treatment in any way?***

It will only help. The best of psychiatric treatment echoes best medical practice in that it recognizes supportive family as assets rather than the enemy, even when you are never in touch with them and even when they have their own peculiarities.

Consider that every physician, not just psychiatrists, educates patients about signs and symptoms of their illness, side effects of treatment, and steps to self-efficacy. But what happens when the patient leaves the office? What are the potentials of their support system?

In the best of treatment relationships, the patient designates a key member of their support system whom they authorize to contact the doctor and to get details about their condition and treatment plan. Good practice of medicine recognizes that if the support system is trained and sophisticated, the good work you do in the office extends to the home and community. When situations arise, even when the patient needs to reach out to you, they are less panicked and less isolated in their recognition and reaction to a panic attack, a hallucination, a misperception of the environment, a cavernous low after a rejection, a bad impulsive decision, and an unexpected physical change that may or may not be a side effect. I give patients my cell number and tell them they can call me anytime. If their family members are part of that village of medical support, they can call me if their relative has authorized our discussion.

There are those, however, who choose to isolate. Paranoia, family antagonism, intrusive or manipulative relatives, and other insecurities are just some of the reasons patients shut down access to family and caregivers. Indeed someone else who pays for treatment, transportation, food and shelter may feel entitled to access to the physician, but it's always the patient's call and is respected and protected. Sadly, that creates a void as soon as the patient leaves the office, and makes any treatment potentially less effective because as soon as the patient leaves the office, any of the above challenges that arise must be handled alone. If the patient calls me, that patient is the sole informant and I may be unable to gauge the accuracy of the history, the completeness of the account and what I might not have been told, and of course, the seriousness of decline, urgency of the situation, or risk. However, treatment can still be very effective and usually is.

With that noted, as soon as serious mental illness becomes particularly acute, and not responsive to medication changes, unpredictability is the norm. Bad outcome may not come, or it may. There is no accounting for the probabilities. And in the case of the family uninformed, there is no one to help out who is educated, trained, and in a position to give help auxiliary to the treatment. Maybe such help proves to be unnecessary, maybe not. The psychotic patient falling apart and person in crisis, who does not allow support system contact, is akin to a ship sailing in the Arctic with no rudder. Maybe one won't hit an iceberg and will simply drift. Maybe one will.

As a doctor and with current commitment standards of acute dangerousness, you can do nothing more than see the patient more frequently or otherwise, wait for the phone to ring with news that things are more alarming, and hope that nothing irreversible happens first. Usually, nothing does. So one resists any temptation to be heavy handed.

Many vocalized ideas stay that way. If a patient is aware that threats or attacks are likely to be conveyed to family, the patient may be less likely to convey said threats. The mental health professional cultivates a climate in which a person can express suicidal, violent or destructive fantasies freely.

Keeping a patient in treatment enables those ideas to be revisited later, and builds capital with the patient for when disclosure to a family member might be necessary. It is a professional responsibility to explore with the patient the significance and likelihood of acting on those fantasies and actions, and beyond a perfunctory, "Are you thinking of hurting yourself today?" or "You wouldn't really do that (again), would you?" That happens far too often to admit.

When I do not have permission, the best I can do now is attempt to persuade the patient to give me permission. Allowing harm to the health, welfare and safety of the patient without engaging the family ***if*** such contact would protect the patient, and without arguing the case to the patient, hurts the treatment. Such passivity enables personality pathology instead of setting limits and conveys treater indifference when the patient needs just the opposite.

The ability to communicate to caregivers or intimate family during crisis situations is therefore a therapeutic tool in the toolbox. If it is unnecessary, it stays there. When it is needed, it can be relied upon. In some crisis situations, there are solutions that do not warrant communicating with the family. On other occasions, the prospect of communication, if the patient does not welcome it, can be a treatment negotiation that results in the ultimate goal of protecting the parties at risk.

Consider the situation of a husband who speaks of repeatedly beating the stuffing out of his defenseless, dependent, and submissive wife. A person behaving this way is not going to be responsive to "Have you considered how she feels?" That person might better be coaxed with:

"Have you considered what the reaction of your brother (who employs the patient) might be about knowing you have been injuring your wife?"
"No. He might fire me, or tell my wife's family."
"Why is that?"
"Because he's like that, and he likes them."
"Isn't that reason enough not to keep doing this?"
"She doesn't like to go out, and she doesn't like to talk to them much lately."
"So? What difference does that make?"

"She's not going to tell them, and no one's going to see her."
"So? Why does that matter?"
"He's not going to find out."
"But what would be his reaction.."
"Who cares? He's not going to find out"
"Are you aware that as a physician, I have responsibilities to ensure your safety in treatment and to keep you safe from any consequences of your behavior?"
"Yeah, yeah."
"What does that mean to you?"
"I can handle myself, but thank you. I'm not suicidal."
"What about your wife?"
"Oh, she's not about to go out and get a gun."
"How do you know that?"
"You're kidding me, right?"
"Well, the situation at home has to be getting worse for her, no?"
"She wouldn't dare. No way."
"Don't you think you might go too far at some point?"
"I probably already did when I broke her nose in May."
"And now you're telling me about clumps of hair on the floor?"
"Whatever. I don't like you going on about that. That's not helpful."
"Well I am your psychiatrist, and I am telling you this is not going to end well. And you are here in treatment so you know you have issues."
"OK doc, so fix me."
"I'm trying, but I have not yet been able to get you to hit a pillow instead of your wife's face, have I?"
"Maybe I need a better doctor."
"Maybe you need to stop beating the hell out of your wife."
"Oh, please. Yeah, maybe. And maybe not, but when I do it, it just happens. What can I say?"
"Which is why I asked, if I was your brother, and we were having this discussion, would you say the same thing to him?"
"Come on."
"And what would he say to you?"
"I don't know, but I can't have him fire me. I need the job. And my wife knows that, too."
"Would he try to keep you from being violent?
"Probably. I don't know what he sees in that family."
"Wouldn't you be glad you talked to him about this before something happens that you can't hide away?"

"Yeah, well, nothing's going to happen. Come on, Doc."
"Well something keeps happening, and it's my judgment that you are creating a risk for an irreversible situation. That's my call, and if your wife were here, she might agree."
"Look, I don't really want this to happen, and I'm sorry it keeps happening"
"OK, so how are you going to keep this from happening?"
"No divorce. I will not lose the kids."
"That does not answer my question."
"So maybe you should refer me to someone else."
"Maybe. But that does not change my responsibility to prevent an irreversible risk."
"Oh well, I'm sorry if I cause you stress."
"You are putting me in a situation where I have to keep the home safe."
"What?! Seriously?"
"You won't stop and you can't stop. You won't stop with another doctor and we both know that. So what do you suggest?"
"I don't know what to tell you."
"I suggest someone who is on your side. And your brother is all you got."
"You want me to go to him?"
"Is that a bad idea?"
"Awww. I'm not gonna do this, and you're not going make me. This is ridiculous."
"Well, do you have someone else in mind?"
"I'm here. I'm talking plenty. That ought to be enough, and if it's not, tough."
"Well, if there's no one else, and you can't do it, why don't we do it together?"
"Are you serious? Are you serious? Are you serious?"
"As serious as a trip to the emergency room with a busted nose."
"Ohhhhh myyy God! I said I was sorry!"
"And you need to be serious because you've got me totally on your side, and you need to respect that by getting serious about how we're going to keep this from continuing."
"You have a better plan to shut the violence down now that does not involve you avoiding me, fine. What plan is that?
"No, but you are upsetting me with this"
"OK, so do we call your brother together, do I call him alone, or do you have another plan for us to discuss in the twenty minutes remaining of our time together?"
"Oh, hello Phil, and did I tell you I am seeing a shrink? Yeah, sure!"
"Look, what you are doing is going to get you arrested with a violent crime charge or will cause someone in your wife's family to eventually get violent with you in a way you never saw coming. So let's make a plan to get your closest supports to help you avoid making these kinds of choices or to better employ strategies to keep you sober, fine? Is there anyone better situated than Phil?"

"Let me think about it."
"Alright, I'll just sit and wait while you do."

What treatment benefit is to be gained from sitting idly by as these behaviors continue, without using the treatment alliance to forge a safer home before it is too late? Modifying HIPAA to enhance the protection of others as above, and in a collaboration as per above, is a valuable tool for risk management when the provider has discretion and acts judiciously using day to day skills and the frequency of the given treatment alliance.

Let's consider whether the above patient was suicidal, and the son of Pat Milam, who testified a year ago before the Energy and Commerce Committee. None of those advocates who would now shut Pat Milam out from vital information that could keep his son safe know or concern themselves with a son who is never coming back.

This reminds one that a psychiatry "survivor" is in fact a person who survives the morbidity of its illness, as in a cancer "survivor." Those who argue "survivor" refers to psychiatry itself bring one's own unresolved personal anger and denial to a Subcommittee pledged to deal with serious mental illness, and mental health crisis. Let us be reminded that Matt Milam is not a psychiatry survivor, because he killed himself within his serious mental illness. My professional experience tells me that Pat Milam's son would rather be alive today and be a survivor, too.

Semantic arguments about what are "erosion of privacy laws" and the "disrupted doctor-patient relationship" are devoid of any appreciation for how the treatment alliance is an alliance as much as any relationship has its disagreements that are worked through. Privacy laws are not the omerta of organized crime; they are meant to respect the dignity of those who are able to respect their own safety and that of others. And then what, when one can't?

5. ***As a forensic psychiatrist and as provider of medical services with more than two decades of experience treating patients, are there situations that you have come across that !cad you to believe that the imminent danger" standard is unworkable and/or limits access to necessary medical care?***

It is irretrievably unworkable.

In my professional experience, I have also treated numerous people who have been repeatedly violent. Imagine treating someone who has assaulted (raped, or murdered) before,

has no apparent inhibitions to doing so again, and having the burden of considering whether to notify that person's caregiver or responsible family in case of deterioration.

My professional experience teaches me that to do so would place me at risk. My professional experience also teaches me that to not do so may also place me at risk.

Most important in weighing these competing interests, however, is that when any risk exists, to the patient, unseen others, or to me, the consequences of waiting for me to calibrate "imminent enough" to be allowable by law create ongoing an unacceptable risk to the community that is unfair and untenable.

Those who think differently do not know what it is like to treat truly scary and unstable people. Nor do they appreciate the despair of the tragedy they could not prevent because the law technically prevented them from preventing a problem that professional's judgment felt was inevitable.

I have also worked in several different emergency rooms early in my career, supervised others doing so, and I know what it's like to be on call at all hours and with a full ER.

In some instances, a person comes brought by police with a report of high agitation and nothing more, and the person appears calm when you examine him. You ask all the usual questions. He says he is neither a danger to himself or others, you have some reason to believe that he was drinking and his buzz cleared, or that he does not have a psychotic condition, or his meth is out of his system. You discharge the patient who insists he does not want to come in. He disappears into the void and anything can happen.

In other instances, you may wonder whether he has a psychotic condition. He may smell poorly, and tell you he is homeless. He may tell you he hears voices. You may choose not to believe him, because he may be looking for a place to sleep. You may choose to believe him, but know nothing more about what his voices are telling him because he is vague, as many with schizophrenia are.

Or you may alternatively find him guarded and uncommunicative as a paranoid person, who self-refers about a vague conflict. That's not enough to tell you what his violence history is, or his plan if he has been violent in the past. What, after all, is "imminent" about something that happened years ago?

Or, like many referrals to emergency rooms, there is absolutely no medical record available.

How then, is one to know that a person is imminently dangerous without having already been violent or suicidal? Yes, one can make an informed decision about "imminent" dangerousness. But the time available for assessment and decision-making, the paucity of valid and reliable data, and the motivation of the examinee to not be committed all conspire to disadvantage the examiner and to conceal imminence that may be just out of view.

The emergency room doctor gets no criminal record or reports of contact with the justice system. Exactly what would tell him that a person is imminently dangerous when the person who is the most detailed historian available knows that he won't be admitted if he is quiet and professes no wish to harm anyone?

Do you really know a full situation as that examining emergency room attending, even when you contact home and family and they speak to you? What if the family is not very verbal or animated and cannot capture the intensity of what you do not see? Even if your gut tells you as a physician that something is wrong, unless you feel something is imminently dangerous, you cannot admit.

Even if you play your gut but cannot substantiate it, the patient will convince another doctor to sign him out so that a person who has already been seriously injuring others and who waits in the emergency room for a bed to open up can then be admitted to a restricted census of spots for hospital treatment.

At the opposite end of the assessment spectrum is the person brought in by family. That person reflects a calm demeanor and refutes the notion that she is even ill. The family you meet with, however, has a very different account. They speak of how confused she has been and that she has refused care. They don't know, however, of any indication of her illness.

Indeed the "imminently dangerous" standard is unworkable.

Risk assessment has been well-refined in recent years. The latter point is significant. For as much as we have learned in psychiatry about predicting risk to one's self or to others, risk assessment continues to be an exercise of low vs. lower probabilities. Violence among the mentally ill is low. Some how does one know whether it is imminent? Especially when the evaluation of seriously mentally ill person is informed by the very examinee who does not want to be committed, knows the standard as well as the examining doctor, knows what to say in order not to be deemed dangerous, knows to go to a hospital where there are no

medical records, knows not to give telephone numbers of people who know him, because they will be called by the ER physician.

However the ability to predict dangerous is informed, and however more specific the data must be to appraise "imminent," these obstacles in the face of public safety render "imminently dangerous" an unworkable term for responsible public safety.

From a patient welfare standpoint, it is likewise unworkable. The patient who is descending into crisis or into more acute phases of a serious mental illness may have the one professional encounter with an examiner on a given day. There may be obvious deterioration and uncertainty as to where this is leading. Included in that uncertainty is the inability to realistically contract with a very sick person to return to the emergency room should his condition "worsen." How, really, would a person that impaired know the difference between "really sick" and "really really sick?" That voices aren't just angry, they're really angry?

These reference points quite obviously do not embed in the experience of what is happening in the mind of the acutely ill person presenting for the emergency room.

What of the seriously mentally ill person who is acutely ill but not suicidal or homicidal? The discharge decision may be obvious. So, too, is the downward trajectory. It may not be imminent. Does he return to the trauma ER only because he was attacked and knifed because he became agitated with the wrong person? Or does someone else end up in the morgue because I never knew he was a sex offender, with a predatory history, and he presented only as "stressed and unable to sleep?" The people we discharge may not keep in touch, or become so ill that they no longer mobilize to seek help. When they are lost, or others lost because of them, that is likewise evidence of how the "imminent danger" standard fails those who should be routed into help but never are until the unthinkable had happened.

Washington Navy Yard shooter Aaron Alexis, for example, was examined in three different emergency rooms over the course of six weeks before undertaking a mass shooting. He might not have been imminently dangerous on any of those visits. When Alexis decided to be dangerous, asking a psychiatrist what he thought was no longer an option. That is representative of the problem we are facing today, even under the circumstances of the most competent assessments.

Of all of the reforms contemplated to make a difference in crisis mental health, reforms to 1) thresholds for involuntary commitment that account for the degree and pace of

deterioration (as is done in HR 3717) and 2) refinement of HIPAA to enable a lifeline to families supporting those in crisis, are the two specific changes that directly impact public safety. **Crisis mental health reform is not real without them**. Both remedies require no costs or additional programs; only the willingness to engage denial and to be decisive as good physicians must be, and to respect the responsibility that families take for crisis intervention.

6) There are some experts who believe that HIPAA and FERPA are sometimes not well understood by families and health providers. In addition, some providers, especially those who are asked to provide private health information before establishing a professional relationship with the patient, are concerned about liability. If fear and lack of knowledge are factors in applying HIPAA and FERPA, would training be a better option, in some cases, to changing the laws related to both HIPAA and FERPA?

Better explaining HIPAA and FERPA will change nothing. Laws are "not understood," by not just the physicians, but the well-lawyered institutions who support them. As hectoring as hospital risk management departments are about training, it is safe to conclude that if providers "lack knowledge", it is specifically because the attorneys and executives of their facilities feel they are better off not knowing.

Clarifying FERPA was the solution recommended after the 2007 Virginia Tech massacre, when investigations described "information silos" that were not communicating about Cho Seung Hui's slow disintegration, certainly not to the close-knit family to whom he showed only respect.

Even with attention to the claimed misunderstanding of FERPA, tragedies originating on campus with troubled youth continue. These include even those identical to Blacksburg, for example, the mass shooting by a University of Colorado Ph.D student, James Holmes, in 2012, and Pima Community College's Jared Loughner.

When the higher educated do not respond to well documented academic articles that educate, perhaps it is because they do not wish to be. One never has to understand what one avoids having to understand.

Education has demonstrated that even better training and awareness about FERPA won't eliminate the tragedies that stirred this committee to action. All it takes is one information silo. And so it is with HIPAA and the medical community. Why is this?

HIPAA's emphasis on privacy as sacrosanct. Current treatment providers respond to the spirit of HIPAA rather than its letter because liability fears are not rational and not explained away. Institutions do not reward psychiatrist initiative any more than they reward surgeons who take chances with good intentions. This is why mental health professionals, practicing defensively in an era of unregulated liability litigation, do not want to do anything to risks angering a patient or trip-wiring the bureaucrats of risk management. Education would not overcome their discomfort over breaching the current version of HIPAA, either.

And, since imminent dangerousness or life threatening conditions are so often arguable assessments, psychiatrists simply invoke HIPAA as a pretext to remain silent and inaccessible and avoid the drama. Having practiced in institutions, there is no understating the intellectually sclerotic leadership that so consistently controls day to day medical practitioner decision-making with pathological risk aversive policy (overt and implied). HIPAA's increasing dominance has browned out the standing of family supports in treatment; mental health professionals have difficulty shifting into involving them.

HIPAA as it is now worded is promoting psychiatrist and psychologist passivity and inaccessibility in the face of crisis and deteriorating clinical situations that families can help to defuse. Sadly, it is the path of least resistance to avoid responsibility for patients who are drowning in their mental breakdowns or crises by simply hiding behind HIPAA to shut families out.

That is a day to day reality for many Americans, not just those such as Pete Earley and Pat Milam, who both testified to this effect before the Subcommittee on Oversight. It is also my testimony that this is how mental health professionals typically, if not universally operate.

HR 3717 protects providers who care to be responsibly available to valuable and devoted family and caregivers in enabling crisis management to extend beyond the doctor's office. It encourages treatment providers that there are professionally acceptable alternatives to hiding in HIPAA when the patient's world is clearly on fire, and to involve caregivers in the bucket brigade even if the patient later curses us all for being wet.

The Honorable Michael C. Burgess

1. ***Do you think the "Helping Families in Mental Health Crisis Act" takes the right approach in addressing the problems with the only "one drug" per therapeutic class policy?***

I do. As a clinician repeatedly board certified in clinical psychopharmacology, I have been treating folks with medication for over twenty years. As a point of reference, my practice specialized in those who did not respond to treatment and in treating those reluctant to participate in treatment.

With consideration to my earlier responses about those reluctant to participate in treatment, the best way to instill confidence in psychiatry, even in the person who denies illness, is for treatment to be effective. However, treatments for many are not magic bullets that cause full recovery. Even if, for example, seventy percent of patients would be expected to respond to a given antidepressant, partial response is exactly that. For those who have partially, if significantly, responded to a medication, combination medication treatment is the delicate exercise of getting a person all the way back with **no** psychotic symptoms, **no** depressive symptoms, **no** pathological compulsions, **and no** pathological impulses. The difference between symptoms being 70 percent better and 100 percent better is enormous, from a standpoint of quality of life.

Even if one practices, as I do, with emphasis on holistic adjuncts to treatment, promoting work, structure, healthy relationships, diet and fitness, a person with severe mental illness or in mental health crisis still has to recover to the degree that one can mobilize to employ these strategies. The psychiatric professional relies upon an array of medicines in each class that may be used in sequence or in combination, with choices that are unique to each patient's history, medical concerns, drug sensitivities and side effects, lifestyle, and previous responses.

It is not correct to guide policy on psychopharmacology as if one is allowing for vitamins. Clinical practice does not distinguish antidepressants, for example, like Vitamin D. If you take something with the recommended amount of Vitamin D, the amount you need is the amount you need, regardless of who is the vitamin manufacturer. There are different subclasses of antidepressants, which target different symptoms and subtypes of depression. Even within subclasses of antidepressants, such as SSRIs, there are meaningful differences between the medications. I have patients in my practice, to that end, who have been on four different SSRI over the course of their treatment (for a variety of reasons) and numerous more antidepressants.

Medication treatment response, in my experience, is unique to the individual. That means that while clinical experience and excellent training and study guide one to make more prudent decisions, each patient that needs medication treatment is going to respond to one medication (or more), and may be the only patient of a group that belongs on that particular medicine. We try to be correct with that first decision, but sometimes we must change what is not working. It is no different from how physicians treat hypertension. Different medicines work for different folks, in different amounts and in different combinations.

HR 3717 does away with one drug restrictions. One drug per class therapeutics are untenable

and do not bear any practical relationship to how psychopharmacology is taught and practiced in the real world. Moreover, worsening patient poverty when medicines essential to them are unaffordable, and at a time of their disability, is counterproductive to policy aiming to mobilize people back into a contributing role.

2. ***Will you provide your thoughts on extending the health information technology incentive to mental health providers? I have cosponsored legislation that I think is very important in extending the program to mental health providers so they can communicate and work with primary care clinicians.***

I think it is a great idea. Internists, family physicians, ob/gyn, and other specialists need to have a direct line to their colleagues treating the patient. Any one specialist's assessment, treatment planning, and prescriptions are impacting the patient's history and presentation at the office of a different specialist with a seemingly unrelated complaint.

These provider communications promote interdisciplinary sophistication, bring team care to the patient in a coordinated fashion, prevent delays in waiting for another consultant to review and recommend based on data that can be immediately available, and promote psychological awareness among medical providers and sensitivity to their patients in ways that might otherwise not be possible with the shorter and more physically focused appointments of the internist's office. Psychosomatics is real. So is the need for internists, specialists and surgeons to incorporate information about how people they see are feeling with their bodies. The benefit of that linkage would be many unnecessary tests and procedures avoided because doctors know their patients better.

I have found interdisciplinary communication to be very helpful to my patient care, and experience our care as an extension of their medical care just as I view the primary care physician and medical specialist an extension of my own care. The health information technology initiative enhances that patient care.

The Honorable Gus Bilirakis

1. ***H.R. 3717 modifies the Justice Assistance Grant program to provide training to police officers to recognize mental illnesses and better intervene in situations. Would this help ensure that police officers receive training to recognize a veteran suffering from Post-Traumatic Stress?***

Let me first disclose for the record that I have treated police officers and veterans with psychiatric illness, examined officers for fitness for duty evaluations, have examined police shootings in the

context of the behavior and presentation of the individual shot, and have consulted in the assessment of adequacy of police training to deal with the mentally ill and developmentally disabled, including currently in Albuquerque, New Mexico.

As the Subcommittee knows, the Albuquerque Police Department has been the subject of a critical report from the Department of Justice this month. The DOJ report is not without its notable shortcomings, but criticism can focus to needed improvement to how police respond to mental health crisis. HR 3717 is a solution that provides for gaps in police officer training in many jurisdictions today. The legislation has a vision for enhancing police response to mental health crisis, enhancing departmental partnerships with families, and training police officers to be extenders to mental health professionals for those suffering whose denial turns them away from help as their symptoms worsen.

With that said, let's first recognize that police officers confront symptoms of mental illness more than ever before because of numerous factors:

- Because of deinstitutionalization, more individuals with serious mental illness are maintained in the community than ever before. Commitment standards of imminent dangerousness, coupled with the far more curtailed length of hospital stays under current medical economics, push more acutely ill individuals into the community. Even if not dangerous, their behaviors may inspire complaints from passersby or neighbors. Or, their disorganization may include law-breaking.

- Family disintegration is far more common in contemporary America than in earlier decades. Many acutely ill who would have been absorbed into caring structures within families are living unaffiliated lives. With no one looking after them in the family, if they become increasingly disorganized, they encounter police.

- The nation continues to labor under an economy of unemployment and underemployment. Economic adversity contributes to emotional illness, substance abuse, suicidality, and domestic strife. Some of the most perilous encounters occur in officer responses to domestic disputes involving one of more of the above factors.

- Communities, especially cities, have more dynamic population flows. Many areas reflect less neighborhood connectedness and mindfulness to those who are struggling. Social infrastructures of cities with an eroded tax base and other budget priorities may offer poor supports to the seriously mentally ill or those in crisis. AOT, for example, is of only recent vintage and available only in certain areas. It is easier in cities and communities with more limited social infrastructure for those with serious mental illness or in mental health crisis to drift toward tragedy. At that point, behavior eventually brings police contact because there is no other source of intervention to a crisis that can no longer be ignored.

- Lengthy participation in the combat theater has left many military returnees with post-traumatic stress disorder. The symptoms of the condition may be hard to confirm and to identify. Reintegration from the military has many challenges beyond merely the presence of posttraumatic stress disorder, traumatic brain injury, amputation or other physical disability.

- More are recovering from head injury with greater independence than ever before – veterans and non-veterans. Head injury may be disinhibiting, among numerous less pervasive but enduring effects. Impulsivity, disinhibition, poor judgment, or bad temper manifests between neighbors, in road rage, at the workplace and may contribute to complaints to police. Sexually inappropriate behaviors may likewise reflect traumatic brain injury's effects on the above. Those same qualities may likewise afflict someone who has a firearm and is encountering police, and therefore reflects a potentially even more dangerous subject.

- Substances of abuse now include such homemade concoctions as crystal methamphetamine, bath salts, and synthetic marijuana, which are known to instigate wild and out of control behavior that may not be responsive to customary de-escalation. Recognizing the history of intoxication and its relative time course may defuse a situation by simply containing it, but the affected party is quite volatile in the interim. To appreciate how dramatic this can be, I'm reminded of a California case in which we were recently called in which police were called to a scene where two professional fighters had been partying with their girlfriends. Police arrived to find one holding, in one hand, the heart of his friend, which he had torn out with his bare hands, along with his eyes. Yes, that level of destructive fury presents to police, with no toxicology screen beforehand.

- Autism is more common than ever before. Less obvious developmental disabilities may result in behaviors that are misinterpreted as aggressive and threatening. As demonstrative as the social inappropriateness of autism is, it is not socially predatory. Those who attribute developmental disabilities to their own predatory behavior, on the other hand, stigmatize others with autism by creating false fears that violent motive is an expression of autism. It is not. Autism is a style of relating, not a deviant ideology; those with developmental disabilities who are deviant are so for reasons ranging from concurrent paraphilia (sexual deviance disorders) or personality disorders (sociopaths and psychopaths) or mood or psychotic disorders (Adam Lanza, for example).

- Contemporary American culture idealizes recreational public drunkenness, especially on college campuses, during spring break, and in association with the most popular and most physical spectator sports and at times of extreme celebration. Numerous corporate interests promote it. Alcohol is more directly causal of violence than even heroin, stimulants, marijuana or cocaine. The public health problem of alcohol and violence has been completely neglected while police departments confront its public expression. Laws regulating alcohol use in motorists, or promoting responsible vending of beverages at stores and bars cannot impact domestic disturbances in which police engage well-lubricated

members of the general public. Under such circumstances in which citizens cannot interpret their environment rationally, any presence of police in their home may endanger officers.

- Lawlessness during certain political activities may accompany important events such as the G8 Summits. As the Occupy protests, which I personally visited and observed in New York City demonstrated to me, these spectacles attract disproportionate hordes of news media eager to provoke chaotic behavior by those in turn attracted to their cameras. Like other spectacle crime by attention seekers, when the television cameras go away, so does the public disorder and threat to public safety.

- Incidents of police misperception of aggressive but otherwise harmless displays, mishandling of incidents due to cultural illiteracy, sadistic overreaction in power struggles likewise contribute to a cultural paranoia. The anger of tragedies is stoked by socially irresponsible news media and those dependent upon media attention who provoke unrest and poison relations between the police and African-American communities, particularly in some cities. In turn, the encouragement of violence toward police in popular entertainment and the idealizing of an anarchist thug culture engender fear among police.

- Gang violence occurs to a degree never before seen in earlier decades. Youth opting for such choices include a substantial population with diagnoses stemming from substance abuse problems, oppositional defiance and conduct disorder, to the emotional effects of early abuse and neglect, posttraumatic stress disorder, or depression. Adolescents, now given more far more lenient consideration by courts, endanger law enforcement because they are deputized by senior gang members who know younger offenders will see only short-term justice consequences, even for violence. More unrestricted traffic into the United States from its Mexican border further confronts officers with gang soldiers who culturally have no hesitation about killing anyone, including law enforcement.

- Flashmobs of looting in broad daylight draws even participants who often have no criminal records and abandon inhibitions due to group reinforcement. These often involve school age children, as does the hate crime most well known as the knock-out game. In my professional opinion, the instigation of a sociopath leader, group reinforcement, and poor police training and lack of initiative in the schools enables greater lawlessness.

- Contemporary school culture sharply restricts teacher discipline even as it tolerates the permissiveness of teacher-student sexual exploitation. Those who misbehave are accommodated, and when behavior escalates to a more shocking degree, law enforcement now steps in instead of the emasculated school administration.

- Those with developmental disabilities are especially prone to victimization, particularly the intellectually disabled. We now more readily appreciate that mental retardation is not always visible to the naked eye; police must be able to better recognize the adaptive subtleties of intellectual disability in order to better flag the vulnerable and potentially victimized.

What is most notable about the above observations, based on my experiences from litigation casework? That psychological sophistication incorporates local elements of culture by necessity. How else to really determine normal from not normal? And, that knowing diagnosis is but a small part of the mental health universe that law enforcement needs to be trained in and to master.

In my professional opinion, too much emphasis is placed on recognizing diagnoses of illness as opposed to symptoms of psychopathology. When one is too oriented to ascertaining whether a person of interest has the symptoms of post-traumatic stress disorder, for example, that officer may make the mistake of looking for an illness as if collecting its criteria in a treasure hunt. If the diagnosis is present, that's a good pickup. But if it is absent, a person may still be very impaired and in need for help, but overlooked because the seriousness of their situation is equated with the presence or absence of post-traumatic stress disorder.

In my professional experience, those with PTSD actually pose very little risk to others. They are numb and reserved. On the other hand, their flashbacks may be startling to witness and may specifically be responsible for high agitation.

More importantly, if these veterans have **dissociation** with their PTSD, their behavior may become chaotic and even destructive. It is the **hypervigilance** and **irritability** of posttraumatic stress disorder that are most associated with violence toward others; the **hopelessness** of the condition that most directly links to suicide, and self-medication with **alcohol** that facilitates or may directly cause suicide or homicide.

Yet dissociation, hypervigilance, irritability, hopelessness, and alcohol intoxication are also symptoms of other conditions – and sometimes, no conditions at all. This teaches us that it is first important for law enforcement to recognize not only symptoms but the potential public safety implications of those symptoms, as well as how to defuse non-directed agitation without violent confrontation.

There are advantages to law enforcement training in diagnosis, however. An officer who does correctly identify posttraumatic stress disorder may be the first to identify child abuse or a battered woman. Jaycee Duggard, kidnapped from her family and held captive for many years, would have been flagged by better police training to recognize PTSD. Investigators operating within polygamous sects, notorious for enforced silence, can use such training to distinguish the numbing of PTSD in an abused adherent from uncooperative obedience to the elders. Better recognition of dementia and delirium, likewise enhances law enforcement's ability to respond to the needs of the elderly who are in harm's way but cannot articulate it as such.

In that regard, one of my criticisms of HR 3717 is that it needs to better appreciate that major mental illness is not limited to the schizophrenia spectrum, bipolar disorder, and depression, but encompasses severe personality disorders, dissociative disorders, dementia and delirium, autism, and

severe PTSD. Doing so will not only enhance the approach to mental health crisis by law enforcement, but by the other relevant disciplines as well.

2. ***HR. 3717 requires the collection of law enforcement incidents involving individuals with mental illness. It seems to me that Veterans suffering from Post-Traumatic Stress would be an important sub-section of this data set and that the information collected could have value. Will you talk about some of the problems that occur, and why collecting this data is important?***

I have had occasion to work on a variety of matters involving returning and enlisted military, encompassing the Iraq and Afghanistan theatres, those stationed in Europe, and worked alongside US military for a number of weeks at Guantanamo Bay while examining an Al-Qaeda detainee. These experiences have been enlightening and have focused extensive study on the problems ahead of us.

There is no doubt that PTSD is well-represented among returning veterans. However, in my professional opinion that the emotional challenges and conflicts particular to the military population extend well beyond PTSD and what is diagnosed. Data collection is therefore important to open our eyes to what we might not yet appreciate, and what might be overlooked from the veterans' affairs agencies with whom that person is affiliated. Certain emotional issues may not yet be appreciated by the individual, and may not have manifest while in the service. He only seeks help with the continued prodding of others who know him well and recognize the little things about what is now "off," or he may not seek help at all.

Untreated and closet substance dependence, atypical presentations of depression, family violence following poor adjustment to civilian life and changes at home. The manifestations of head injury may be quite subtle; if they are cognitive, they trouble the patient. If they are behavioral, they trouble others – and may not be reported by the examinee until he is around others for a length of time.

Furthermore, there are conflicts unique to each of the Iraq and Afghanistan settings. The Afghanistan experience was so primitive and with such shifting loyalties among locals that servicemen were in conditions in which they risked limb and gave life for hearts and minds that ranged from fearful of reprisal, turning on them in attacks of betrayal, or altogether indifferent.

In Iraq, American displacement of Saddam Hussein and the rebuilding of Iraq was warmly received, and many Americans connected with an educated populace and more developed nation and its people. The American withdrawal, was quickly followed by the expansion of the Iranian terror-axis, which now dominates Iraq as it does another multi-sectarian neighbor, Lebanon. Veterans are now confronted with feelings of futility and demoralization over their sacrifices as other aspects of American impact reverses.

Our veterans voluntarily enlisted and represent the highest civic character of America. Even in spite of the problems they face and how they are changed by their experiences, they are trained to be invested in social order and identify with it. Those who have encounters with police may still represent but a fraction of the returning population. Problems with veterans may remain unappreciated from study of law enforcement contacts precisely because of the morality and character of this subpopulation.

This point deserves emphasis out of respect for who the veterans are and how they have distinguished themselves by their service, for there is an undertone of concerns that returning veterans represent a public risk, because of their demonstrated lethality and because they are presumably traumatized. It is 2014 and returning servicemen have not been marauding lawlessness. I do not therefore expect these fears to be realized.

More recent studies of violence by veterans show that criminal history is the most prominent risk factor for criminal violence in veterans – not PTSD. Honor survives illness. When it does not, look to the influence of drugs and alcohol, outside social influences, or psychosis.

Social influence is a matter that encompasses law enforcement. There has been increasing representation of different American gangs among U.S military personnel. Researching the returning servicemen will be informative to whether the military experience redirects from gang membership, when it does not, and help us understand the divergent outcomes. American military training is a valued commodity among drug lords and others who operate via the cross border openness with Mexico. I was involved in the matter of one serviceman who parlayed his experience into well-compensated work performing executions for drug gangs in the United States and south of the border. He confidently avoided capture to speak of his experiences while receiving services at his VA.

The moral choices one makes are affected by underlying character as well as social influence. Ex-military man John Muhammad, further alienated in his conversion to Islam terrorized Washington DC and enlisted his eager son. Conversions in prison have also been well-represented among aspiring terrorists. Whether the converted population among servicemen identifies with a coexisting faith or the doctrine of Islamist dominance will reveal itself in time. The radicalized Nidal Hassan murdered before ever being deployed.

Those ex-military whose contact with police officers is laden with social deviance more likely exhibited antisocial qualities prior to entering the service. The current military personnel demands have, in my experience, lowered thresholds on who is cleared to be deployed. What we learn from the data collected from law enforcement will further inform to what degree this is true, and what adjustments need to be made.

If the tools are available to collect data from law enforcement contacts with those who have mental illness, our nation benefits from learning about its veterans in many ways. It is also an act of caring for a population that deserves to be treated as American royalty. Regardless of one's feelings about

the wars, those who serve embody devotion to the United States of America, loyalty to its Commander in Chief, personal sacrifice of training, endurance of the pain of lengthy separations from loved ones, and for some the disintegration of their marriages and families. They have accepted the yoke of psychological and physical burdens that others among us were not of the character to do. They have respected rules of engagement given them of unusual restraint that in some instances, have resulted in their being maimed or too close for psychological stability, and watched friends die. They have been giving and benevolent to people who maintain contempt for them as infidels who are not co-religionists. As our veterans have served us, we owe them our service as a civic duty. If the data collection through law enforcement or other provisions informs that service, we are the better for it.

3. ***Title VI of H.R. 3717 increases funding for the Brain Research through Advancing Innovative Neuro-technologies (BRAIN) Initiative. Will you tell me more about this initiative and would this help in the study of Traumatic Brain Injury (TBI) or Post-Traumatic Stress?***

The (BRAIN) initiative aims to identify how cells and groups of related cells network within the normal and diseased brain. We already appreciated the nervous system as circuitry. It follows that disease includes alteration of that circuitry. If we better understand the points of abnormality specific to certain conditions or certain symptoms, we have far more specific guidance about where the fix needs to be done.

If we appreciate that problems in this circuitry are like breaks on a railroad track, we are given specific direction about where the repair needs to take place. Further study identifies the nature of the repair, and eliminating consequences of that repair. But pinpointing the features of illnesses along circuitry makes for far more specific treatments.

The implications for a circuitry model of mental illness are clearer for head injury. Head injury can sometimes be seen grossly on imaging scans. But more consistently, damage is reflected in functional, or neuropsychological, testing. Identifying neural circuitry affected in head injury and correlating it with functional deficits enables us to pinpoint approaches to healing the brain as if we were healing a wound or torn ligament.

Posttraumatic stress disorder is not as concrete as a head trauma. The BRAIN Initiative will eventually illuminate the circuitry of this illness. However, that may be just the beginning; for PTSD involves problems of hyperarousal, memory, emotion, and fear. Circuitry that relates to disparate functions within the brain will then have to walk backwards to remedy the upstream disease site.

Compare that approach to medicines that target neurotransmitters that are variably distributed throughout the brain. The gross vs. fine treatment of conditions is likewise reflected in the time it takes for the mind to adjust to these treatments, and their reversibility when medicines are removed.

In short, if we can identify diseases by unique networks and circuitry of neurons, our approaches to treatment can one day be as precise and fine as the resolution.

4. ***Title X of H.R. 3717 provides medical malpractice protections to providers that volunteer at Community Health Centers. Will you talk about the challenges that Community Health Centers have in finding qualified staff and getting fully staffed? How would this provision meet that need?***

Psychiatry features numerous subspecialty disciplines. The skills and technical knowledge unique to child psychiatry, substance abuse psychiatry, forensic psychiatry, psychopharmacology, and various psychotherapy protocols demonstrate how these and other subspecialties are distinct.

Updating knowledge is always a pressure, because new discoveries in the brain and behavior and excellent research impacts diagnostics and therapeutics. Only last year, the American Psychiatric Association released it's the fifth version of its diagnostic handbook. In order for me to demonstrate the qualifications of psychopharmacology for board certification, I needed to sit for examination every five years.

Reimbursement is poor relative to other specialties, and it is easier to make a more prosperous living in almost every other medical discipline. Psychiatry suffers a lack of prestige from its origins as iconoclastic, theoretical, and not science-based. The field has matured dramatically into an evidence-based discipline, but psychiatry's lower prestige has lagged. Contrast psychiatry's assessment and therapeutics of the brain – exactly the domain of neurosurgery. Neurosurgery enjoys all of the intrigue of its focus in the brain, and all of the prestige of the life-saving surgery. Psychiatry, on the other hand, is denigrated and even lampooned.

Many shortages exist in subspecialty talent. The same lacking incentives that disadvantage psychiatry from outcompeting other medical disciplines impact subspecialty talent as well. As for child psychiatry, the gap between needs and staffing is so substantial that positions in many areas are already overtaxed.

Community mental health centers are limited in their resources. A general psychiatrist or counseling psychologist may be responsible for the gamut of services. This is akin to a general practitioner being responsible for all medical needs, and for all ages. It may be adequate for many community residents, but the special emotional problems of some children, those of all ages with chemical dependency, those in crisis, and the recently incarcerated with risk reduction issues call upon very different knowledge and clinical skills.

Shortages of mental health professionals in underserved localities carry more serious consequences than medical shortages. The public health system remedies the absence of available acute and emergent medical needs with airlifting and ambulances. There is no airlifting a person in mental health crisis. The medical crisis patient seeks help and will travel where need be for vital care. The person in mental health crisis may be at particular risk for suicide or violence because that individual denies a problem and refuses to seek center-based help. Mental health crisis response approaches, involving counselors, physicians, other allied professionals, and other community supports must be refined in underserved areas.

HR 3717 attaches eligibility for block grants to the community mental health center's success in attracting appropriate staff to provide the range of subspecialty services needed. These also include staffing community mental health centers with staff with cross-cultural literacy. Funding for community mental health centers can only account for some needs, however. Crisis intervention and other counseling can especially be aided by professional volunteers whose skills become force extenders in underserved areas.

Mental health crises may be a life threatening suicide risk or family emergency. Or, community safety may be in play. The human, medical, and material costs of mental health crises may draw liability interest because the outcomes can be devastating. The American public is best served when doctors make room in their careers for crisis mental health and for dealing with the unpredictable course of the seriously mentally ill. A prudent vision from this Congress and from mental health leadership

would be to draw those with the best skills to meet the acute needs of the seriously mentally ill and those in crisis.

Patients in crisis need more attention and follow-up. Doctors may not necessarily be reimbursed for more frequent or more lengthy contact. This is unacceptable. If the importance of heavier outpatient services during crisis must be respected in reimbursement. Otherwise, our government is not treating crisis and acute illness with the same urgency as public safety and homeland security issues.

Given the potential risks, these professionals are comparable to those who perform high risk obstetrics, or neurosurgery. For this reason, liability exposure is also a strong deterrent to potential crisis mental health providers. Bad outcomes, especially suicides and enduring injuries, threaten treaters regardless of the excellence of their effort. Naturally, doctors who can make decisions about how to apportion their time would be dissuaded from working with those who need it most.

Something has to give. Either we create conditions (be they tax advantages, liability protections, tuition reimbursement, specialized training, better reimbursement, for example) that incentivize the best mental health professionals to practice with the serious mentally ill and those in crisis, or we are not respecting serious mental illness seriously enough. We will the keep learning the hard way from tragedies that could have been interrupted, even as we allocate monies or direct them properly. At the end of it all, the toughest patients have to be seeing the best talent. This includes alleviating the reality that conditions for assuming care for the crisis and serious mentally ill patients are too thankless and driving their doctors away. The dialogue within the Energy and Commerce committee has proven that this reality is unsustainable.

In order to advance, therefore, individual constituencies will have to accept the need for adjustments. Trial lawyers, for example, resist any liability immunity discussions for those tasked with the most volatile and high risk. Their position clearly sacrifices remedies to attract top talent to defuse crises in order to protect revenue streams. Congress needs to set limits with selfish resistance that places the needs of a select few over crisis management. Would we not protect our military from liability suits of those hurt or killed while our Navy Seals or Army Rangers or Marines are exercising public service? Are there not qualified immunities for first responders and SWAT law

enforcement who likewise put themselves in harm's way? Why would crisis mental health professionals be any different?

America has already witnessed the byproduct of this liability industry overfishing in the decimation of high risk obstetrics. So unapproachable is liability protection that doctors have simply stopped practicing, and those with special medical needs become unserved in conditions that are more third world. So, too, have neurosurgeons become endangered species with predation.

The gaps in community mental health and crisis mental health that have prompted these hearings and have inspired HR 3717 mandate that we protect professionals performing lifesaving work in the national interest at least as much as we protect spotted owls from rapacious profiteering. And if liability protection to those working with the most seriously mentally ill cannot be compromised, how would our national health needs realistically attract volunteers to underserved community mental health centers?

I strongly recommend to the Subcommittee on Health, and to Congressman Murphy, to respond to the national dialogue that has inspired HR 3717 by **creating a range of conditions that attract the best and the brightest to crisis mental health**. Our nation will owe a great debt to you all, as will those you have a hand in saving.

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