

**REMARKS  
FOR THE  
CONGRESSIONAL NEUROSCIENCE CAUCUS  
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BY  
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Good morning, Chairwoman McMorris Rodgers, Chairman Blumenauer and members of the Caucus. Thank you for putting such an important issue at the forefront of the national discussion.

My name is Dr. Elizabeth Childs. I am a board certified child, adolescent, and adult psychiatrist who is blessed with the privilege of working with many children and their families who face the diagnosis of mental illness and their futures with courage and determination. I've also served as Massachusetts Commissioner of Mental Health, a local school board member, a member of the Massachusetts state Board of Early Education, and have had the privilege of working with Director Tom Insel and Dr. Gur on the NIMH Advisory Council. I hope that my perspective is useful to you today.

Recent tragic events that have grabbed the nation's attention should have put a spotlight on the role of mental health in preventing violent episodes. Instead, it has been little more than a footnote. Untreated conditions such as psychosis have terrible outcomes, of which violent outcomes are the most tragic. A fragmented mental health system and stigma towards mental illness, especially psychosis, exists, not only in the general public but also in the medical community. This unfortunate dynamic keeps these patients and their families in the shadows. If policymakers and the mental health community work together to create and implement a comprehensive and coordinated strategy to improve quality, access, and continuity, fewer innocent lives will be lost and fewer families will experience the unspeakable heartache of losing a child.

I'd like to start with a story. This one doesn't have a good outcome. Despite our best efforts sometimes we fail, in large part because of a broken system we have for identifying, tracking and treating mental illness early and with continuity.

A number of years back, I was called to the ER to evaluate a 14-year-old boy. He was a gangly, scared kid brought in from home because he was out of control and throwing things. He had been expelled from school for threatening to hurt other students. (The first system failure.) His parents had tried to get him counseling but he refused to go. (The second system failure.) When I first saw him, he didn't want to have anything to do with me. But after I explained to him that I had nowhere better to be than right there and I would just sit with him and wait, he began to open up. He told me that he was hearing voices commanding him to kill his parents. These were very real to him because the voices came through his ears just like my voice is coming to you.

I began the process to hospitalize him with a conversation with his parents. They were shocked and did not believe that he really had these symptoms. How could this be? He had told no one. Once they accepted that what I was saying was true, they felt helpless and angry--they had tried to get him help but nobody would help them. They were devastated that their son had a mental illness. He was safely hospitalized and engaged in treatment. It was a rocky course with many stops and starts, cycling in and out of treatment with hospital readmissions and brushes with the law. (The third and multiple future system failures.)

Finally, after eight years of fractured treatment, he was readmitted to the hospital and convinced his umpteenth treatment team that he was safe to return home. He was discharged. He did not follow up with treatment. (Another failure.) A short time later he murdered his mother and stepfather with a knife and then shot himself with his stepfather's gun.

This was of course a horrible and tragic outcome. People with mental illness are four times more likely to be the victims of crime than to commit a crime. Most people with mental illness do not commit violent actions. It is critical to address issues of violence among persons with mental illness who may be at risk of committing violent acts, but it is important to remember that mental illness does not automatically equate with violence. Treatment really does make a difference and the earlier, the better. Untreated psychosis increases the risk of violence up to six times the risk in the general population. Most of the time this violence is directed toward the person himself, which is a tragedy for the patient and their family. Occasionally, it is directed toward others, creating further devastation. These are the episodes that have been seared into our national consciousness.

Now, I'd like to tell you a different story. Sometimes we succeed. This is the story of a child whose parents knew how to access mental health services. They recognized that something was not right by age four and had him evaluated and treated. When he was eight he took an axe to their trees and fence with a bizarre explanation that did not make sense, so his parents continued treatment for his developmental disorder with another clinician. At age 14, he was referred to me for treatment because, "he just seems lost, like no one knows him."

At first, it was slow going. He wasn't sure why he was there, but he came. His parents were very invested in his treatment. After two years, he acknowledged that he was hearing voices directing him to do bizarre and dangerous things. Because of our strong and continuous relationship, he agreed to medication.

We met together with his parents to explain how important it was that we treat the psychosis definitively. At first his parents could not believe that this was possible. How could this be, and why did we not know before? Prior treaters also were skeptical that this was psychosis. Denial is a powerful and difficult symptom in psychosis in the patients themselves, in the family, and even among mental health providers.

Over the course of two years, with gradually increasing doses of medication and consistent treatment with psychotherapy to practice social interactions, supported work programs, tutors, life skills supports, college based counseling and lots of family love and involvement, the symptoms diminished. He is now successfully attending college. It is important to him

that I spend a day on campus with him each year so that I can fully understand his life when we meet on weekends and over his breaks to maintain the relationship that keeps him compliant with treatment

Just this year – nearly five years into our work together, he asked me what causes this terrible anxiety. I told him that he has schizophrenia and that it is treatable, as he has already figured out. We talked about the risk of symptoms recurring that compromise his own independent ability to judge what is right and wrong and real. More than anyone he wants those symptoms to stay away. We don't know what his future will bring, but we have a solid foundation on which to cope with the challenges that life will bring. Although he will need ongoing treatment throughout his lifetime, he will be able to live a full and productive life.

From a child psychiatrist on the frontlines I will try to summarize for you what I see that makes a difference, what works, and what I wish we could do to make more of a difference.

First, we must recognize mental illness as a public health issue in our communities and schools and raise the awareness of adults who interact with our youth to recognize the warning signs of emotional disorders. These are serious illnesses, which forever change young lives and their families, and when left untreated, can lead to broader tragedy. Yes, these illnesses can be frightening but they are also treatable.

Denial and fear are best met with empathy. Empathy for the devastation of mental illness is so lacking within the mental health community and society at large. These kids and their families are repeatedly judged and stigmatized, especially at school. Aside from the scarcity of services, the emotional toll of asking for help is shameful and painful.

Stigma is best met with education. I would recommend that we undertake a nationwide effort, implemented by the states, of public awareness campaigns for recognition of the onset of psychosis. This campaign would specifically target parents, teachers, faith leaders, primary care providers, police, juvenile court personnel, libraries, community centers and youth volunteers of all ages. Asking just one question on State Education Comprehensive Assessment Tests about mental illness would assure that the basics of brain science and mental illness are included in the curriculum and that teachers are aware enough to teach it.

This effort would dovetail nicely with some of the good work currently done across the country using the Adverse Childhood Experiences Study (ACES) to understand and identify early children at risk for poor health outcomes, including the onset of psychosis, high health costs over the lifespan, and tragic social outcomes such as imprisonment and homelessness. At least 18 states have followed Washington state's lead in using ACES to guide public health interventions for these youth at risk.

Adolescents struggle with isolation in our increasingly aggressive and technological culture without the grounding influences of real human connections. Model youth programs are not a substitute for effective mental health treatments, but these programs can nurture relationships that are a critical context for the delivery of mental health treatment. Examples include Caring School Communities, Big Brothers and Big Sisters, and Promoting Alternative Thinking Strategies.

Children and families are isolated. Families are often alone, with no idea of what might be happening to their child, no community or school support or clue about where to get help, with multiple years (and hospitalizations and arrests) occurring before their loved one gets accurately assessed and treated. I am still struck by how pervasive this problem continues to be. NAMI Family-to-Family program is one example of successfully giving these families hope.

But it is often hit and miss to connect loved ones with mental health services and access ongoing treatments that have continuity, instead of the repetitious and frustrating cycle of crisis intervention followed by discharge and then return in crisis. Our formal mental health and alcohol/drug services still aren't accessible and visible enough to people in the community. Unfortunately if a loved one isn't willing to get help and doesn't meet the threshold of acute dangerousness that forces treatment, families feel angry and helpless and remain isolated. I have no direct insight into the life circumstances of Adam Lanza of Newtown, Connecticut, but from the media focus, it seems that the mother and the son were isolated and on an island together – without getting the help he clearly needed.

When I was Mental Health Commissioner we were in the process of renovating a large medical facility in Boston, which would house one of our state mental health centers. , I insisted that the center be located in the front and center of the building, where people could see the signage from the street and walk in. This wasn't where the architects had envisioned the mental health clinic. Have you guessed where it was first located? Yes, you are correct if you thought down the side access street and around the back by the loading dock. That's the public view of mental health in a nutshell: if we don't see it, it mustn't exist.

The best opportunity to help families access mental health services is to meet crisis with engagement. Engagement is the singular most difficult task when the patient, family, and community are in denial. We have seen success when mental health programs, for example, use Early Intervention teams or Programs for Assertive Community Treatment (PACT teams), assure immediate access to patients in crisis and have capacity to provide outreach and actively engage youth and families confronted with the onset of serious mental illnesses. This type of outreach can and does work, but is only happening in isolated pockets across the nation.

It is not uncommon for a youth with emerging serious mental illness to first present to police or juvenile courts. Diversion programs for first-time and low-risk offenders with identifiable mental illness and alcohol and drug addiction result in engagement with youth and families and maintain public safety.

Since the Sandy Hook tragedy, we have heard numerous recommendations for preventing further tragedies – from arming teachers to strengthening gun control laws. But these solutions are merely emergency band-aids on a much, much greater problem. They fail to address the root problem, which is untreated or undertreated mental illness. If we can work together to increase the public understanding of psychosis and other serious diseases and at the same time create a more cohesive mental health treatment system, then we will prevent countless more tragedies – small and large – from occurring. We will save lives.

Primary care physicians manage and treat the majority of emerging mental illness in children and adolescents. When they need to refer a patient for specialized care, it is critical that even with a critical shortage of child psychiatrists in the country, we respond. As Commissioner, I championed and took to scale the Massachusetts Child Psychiatric Access program, which provides pediatricians a direct phone call to a child psychiatrist for any patient regardless of insurance. Most often the pediatrician needs to confer and can make a referral, but occasionally, the child is referred for immediate assessment. My pediatrician colleagues tell me that this service has changed their lives and their patients and families' lives and that they use it often.

Finally, our youth spend most of their out of home time at school. We must support and encourage school-based mental health services and alcohol and drug services. In my town our public schools contract with our local Community Mental Health Center to implement expanded school-based mental health services. Creating incentives and removing barriers for schools to embrace on site mental health and substance abuse services through creative mechanisms, such as public-private partnerships that are woven into the local community fabric, would accelerate these on-the-ground efforts.

I am well aware of the challenges you face here in Washington to balance our budget, but there are investments worth making, that restore Americans to functioning, to the ability to work, have families, and contribute to all of us. Underfunding of the National Institute of Mental Health and mental health care in general does not move us in the right direction. It is sad, but not surprising, that there is precious little invested in the nation's fragmented mental health system through the \$1.2 trillion Affordable Care Act. The reality is that the lack of investment in mental health is far more costly in the long run, including the increased burden that untreated mental illness has on the nation's education, public safety and corrections systems. And that is before we factor in the incalculable human cost to families and our society.

Thank you for listening to my remarks today. Thank you for your commitment and support for our loved ones and patients who courageously live with mental illness. We who work in this field need and value your leadership. There are many dedicated mental health providers of all disciplines serving these youth and their families. Their care is comfort to many who suffer. Improving the quality of treatment, access to help, and continuity of the care that these children and their families need offers them hope.

I am happy to answer any questions that you may have.