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Testimony of the

American Psychiatric Association

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OVERSIGHT AND INVESTIGATIONS SUBCOMMITTEE HEARING:

Americans in Need:
to the National Mental Health Crisis

Chair DeGette and Ranking Member Griffith, on behalf of the American Psychiatric Association (APA), the national medical specialty association representing over 37,400 psychiatric physicians, I want to thank you for conducting the hearing today entitled, "*Americans in Need: Responding to the National Mental Health Crisis*." The APA appreciates the Committee's continued work on this critically important matter. I also would like to thank you for the opportunity testify on behalf of APA. My name is Dr. Lisa Fortuna, MPH, M.Div. I am a Professor of Clinical Psychiatry and Vice-Chair at the University of California San Francisco Department of Psychiatry and Behavioral Sciences and Weill Institute for Neurosciences. I also serve as the Chief of Psychiatry at the Zuckerberg San Francisco General Hospital. I thank you for having me here today to address the myriad issues surrounding the state of our nation's mental health.

Over the past two years, we have seen the COVID-19 pandemic continue to exacerbate mental health conditions, including substance use disorders. COVID-19 arrived at a time when our nation was already suffering from simultaneous suicide and opioid overdose epidemics, and data show that the disease has impacted just about every single aspect of our lives from economic to job security to health outcomes and beyond.

Mental Health America's Online Screening program, taken by over 2 million people found that 75 percent scored positive or with moderate to severe symptoms of a mental health condition in 2020. Screeners tested positive for mental health conditions like anxiety, depression, bipolar disorder, eating disorders, psychosis screening, PTSD, and so on. Among screeners who scored at risk for mental health conditions, 68 percent had never been diagnosed with a mental health condition before and 64 percent had never received treatment or support for a mental health condition before. The same screening found that the largest increases in the proportion of people experiencing suicidal ideation were among the Native American or American Indian respondents and Black or African American respondents. In addition, a recently released APA/Morning Consult survey found that adults ages 18-34 and those with incomes under $50,000 per year are most likely to report that their mental health is fair or poor. The same poll found that unemployed adults (45%) are twice as likely as employed adults (23%) to rate their mental health as fair to poor. Myriad other surveys over the past two years have found that anxiety and depression levels for parents, children and essential workers, first responders and front-line medical practitioners were the highest. Though these data are nationally applicable, I have seen these results manifest themselves in my own practice.

At San Francisco General Hospital, over 80 percent of individuals hospitalized for severe COVID-19 illness were essential workers who could not shelter in place or physically distance during the beginning of the pandemic. A participatory action research group composed of community members, mostly essential workers, did a study in which they identified mental health and financial devastation as the two most important impacts of COVID-19 on the essential worker community, which is disproportionately majority minority. Further, other studies have found that Black and Hispanic children have been disproportionately impacted by COVID-19 related infection and death in their communities. Their families have suffered inordinate economic setbacks as well, with Hispanic women and immigrants among the groups most affected by job loss during the pandemic according to the Pew Research Center. Young people in these hard-hit

families are at particular risk for food insecurity, unstable housing, lack of access to broadband internet and transportation, and even the effects of domestic violence, which also rises during challenging financial times. So, in addition to worsening overall health for minority communities, the pandemic has also worsened the existing disproportionate impact that social determinants of health have on minority communities.

Health Equity

The APA is encouraged by the Committee's ongoing efforts to address social determinants of health and to reduce health disparities by prioritizing policies and funding programs to advance access to evidence based and culturally competent care. The disproportionate impact of the COVID-19 pandemic on racial and ethnic communities and vulnerable populations has highlighted the necessity of addressing health inequities. Social determinants of health are among the most significant contributors to negative health outcomes and overall health inequity. It is for these reasons that we encourage the Committee to continue to focus on policies that **(1) increase the culturally competent workforce of mental health and substance use disorder practitioners, (2) increase the availability of culturally competent resources for practitioners and states to help them meet unmet mental health and substance use disorder screening and treatment needs in hard to reach populations, (3) work to reduce discrimination and bias in the screening and treatment of minority patients, (4) increase access to culturally competent and inclusive maternal prenatal, delivery and post-partum care to help reduce maternal mortality and severe maternal morbidity, and (5) increase resources for public health campaigns that use evidence-based practices to reduce mental health and substance use disorder stigma, encourage community support and dispel population distrust in the medical profession, specifically mental health practitioners.**

An example from my own experience helps to illustrate the importance of these health equity policy recommendations. Earlier in the pandemic I saw a patient who is a nursing home aid and a mother, let's call her "Gloria." During the early days of the pandemic, Gloria was forced to stop working in her home health job because she was afraid of catching COVID-19 and getting her children sick. Though Gloria left her job, her brother was also an essential worker and unfortunately caught COVID-19 and became very ill, requiring care in the ICU. He was unable to work for over six months because of his COVID-19-related disability, and over the course of six months this same family experienced six COVID-19-related deaths due to similar situations in their extended family.

As a result, Gloria's eleven-year-old daughter developed severe anxiety because she was afraid that her mother would catch COVID-19 and pass away because of her job, and that would leave her and her brother orphans. Gloria's daughter started to have difficulty eating and sleeping and had difficulty concentrating on her schoolwork. As Gloria's daughter suffered from these untreated mental health conditions, Gloria too, between the stress and grief of losing family members, suffered a relapse of major depression. The stress, anxiety and grief from the pandemic had very real mental health repercussions for this one family, and these health conditions also had a complete domino effect on their economic stability.

Gloria's family was able to reach out to their primary care doctor, who then connected Gloria and her children with a therapist to receive mental health services through telepsychiatry. Though not all families have been this fortunate, Gloria's family had access to laptop computers through their children's school so that they could receive services. However, they had to ask for help accessing reliable broadband from the school. Through her work with a therapist via telepsychiatry, Gloria and her children were able to get access to mental health services and also were connected to other social services to help with food insecurity until Gloria was able to start working again.

Telehealth

Telehealth during the pandemic has been a success story for families like Gloria's and many others in need of mental health care. The rapid expansion of telepsychiatry authorized by Congress and the last two Administrations significantly enhanced patient access. Prior to the COVID-19 pandemic, our public hospital (San Francisco General Hospital) could not offer telepsychiatry because MediCal (California's Medicaid program) would not cover it. However, using the flexibilities afforded under the Public Health Emergency, we, like many other systems, went from 0 to 100 on telepsychiatry over the course of a week. In addition to providing telepsychiatry services, we also began coordinating with schools to let them know that we could still offer therapy through telehealth and could offer them consultation services on how to support youth under stress because of lockdowns and remote schooling. Though the pandemic has been difficult for a multitude of reasons, the progress we have made in reaching more patients through telehealth and coordinating care with other systems of support has been a silver lining.

As you know, bipartisan agreement during 2020 allowed Congress and the previous and current Administrations to increase access to telehealth services to treat mental illness during the COVID-19 public health emergency. Prior to COVID-19, substance use disorders and co-occurring mental health services were exempt from geographic and site of service restrictions under Medicare, but mental health treatment services alone were not. At the end of 2020, Congress took the important step of permanently waiving these restrictions for mental health.

However, Congress also passed requirements for patients receiving care via telehealth to have an in-person evaluation with their mental health provider within the six-month period prior to their first telehealth visit and at subsequent periods as required by the Secretary. This arbitrary requirement, which does not apply to those with substance use disorders or co-occurring substance use disorders and mental health conditions who see their clinicians via telehealth, creates an unnecessary and difficult barrier to needed care for Medicare patients with a mental health diagnosis. Whether a patient needs to be seen in person is a clinical decision that should be made together at the appropriate time by a patient and their doctor. **APA supports the removal of the six month in-person requirement for mental health treatment to ensure that mental health and substance use disorder services furnished via telehealth are treated equally**. Further, APA encourages the Committee **to support policies that expand the telehealth flexibilities afforded to providers under the COVID-19 Public Health Emergency, including lifting of site of service and geographic restrictions as well as allowing for the use of**

audio-only when clinically appropriate, and no other alternative exists. Extending these flexibilities for at least two years post-Public Health Emergency is critical to ensuring that all persons, including minority populations and underserved communities, can access behavioral health care regardless of their circumstance, and will allow for Congress to study the impact of these current flexibilities.

Impact of COVID-19 on the Mental Health of Children

COVID-19 has exacerbated the stressors children were experiencing before the onset of the pandemic, as the mental health struggles experienced by my patient Gloria and her daughter illustrate. As was the case before the pandemic, these devastating impacts have a multitude of causes. According to the December 2021 Surgeon General's Advisory on Youth Mental Health, the pandemic has added to stressors that were already pronounced for children and adolescents. The most heavily impacted individuals are part of vulnerable populations including racial and ethnic minorities, LGBTQ+ youth, youth with disabilities, youth who live in rural areas or reside in immigrant households, youth involved in either the child welfare or juvenile justice systems, and homeless youth, among others. The advisory highlighted the fact that as of June of last year, more than 140,000 children in our country had lost a parent or caregiver to COVID-19. Further, the report cited research indicating that depressive and anxiety symptoms for youth doubled during the pandemic while emergency room visits for suspected suicide attempts rose by fifty one percent for female youth and four percent for male youth compared with the previous year. In fact, the mental health crisis became so severe for children by October 2021 that the American Academy of Child and Adolescent Psychiatry, the Children's Hospital Association and the American Academy of Pediatrics declared a National Emergency in Children's Mental Health.

The Mental Health America mental health screening mentioned earlier in my testimony noted that throughout the pandemic, youth ages 11-17 were more likely than any other age group to indicate moderate to severe symptoms of anxiety and depression. The same screening found that eighty four percent of 11 to 17-year-old screening respondents scored with symptoms of moderate to severe anxiety. Youth respondents to this screening reported the highest levels, about eighty percent, for risk of emotional, attentional or behavioral difficulties. Similarly, ninety one percent of the same age cohort who took the screening scored with symptoms of moderate to severe depression. In addition, this screening found that suicidal and self-harm thinking among young people reached epidemic heights in 2020. Specifically, of LGBTQ+ youth who took the same screening, ninety five percent scored moderate to severe depression symptoms and eighty eight percent scored for moderate to severe anxiety.

Multiple factors have contributed to anxiety, depression and other mental health conditions reported by youth. One of the most highlighted stressors throughout the pandemic by both youth and adults has been technological divide. Lack of access to technology like smart phones and laptop computers along with lack of access to reliable broadband have created multiple challenges for families without the means to purchase these items or their availability in their communities. This technological disparity has caused a massive divide between children from families with resources to provide these items, and families who do not. The disparities have

been particularly pronounced for children of color and in underserved urban and rural communities where there simply is no readily available community solution to lack of broadband or technology. Further, children from families without access to technology went from seeing their friends every day in school, to being completely disconnected from many classmates and friends. This isolation from school and peers also reverberates not just in falling behind on studies, but also in important child development milestones and in connecting children with important support services provided through school.

Online Content During the Pandemic

During these intense times of lockdown and social isolation, both children and adults have turned to the Internet, online forums and social media for support and entertainment. Online activity is both an important phenomenon and one that has significant risks, to which adolescents are particularly vulnerable. Connecting with and seeking support through peers online is helpful for many Americans, and social media is often used to maintain personal relationships during periods of physical distancing, however, reliance on social media for social interactions can have negative consequences. Further, some addictive and/or predatory algorithms used by some social media companies can worsen mental health conditions for some patients. **Online activity is also a broader public health concern, and our communities must promote safe engagement with social media and other online activities.**

Workforce

The APA applauds Congress for investing in physician training by adding 1,000 new Medicare-supported Graduate Medical Education (GME) positions via the 2021 Consolidated Appropriations Act. In addition, **we strongly support the proposed expansion of Medicare GME residency training positions by 4,000 new positions with fifteen percent allocated to psychiatry**, as proposed in the Build Back Better Act. APA is hopeful that this GME expansion provision will be passed before the end of the 117th Congress. These GME-related advances, while extremely important, are only part of the solution to addressing current and future substance use disorder and mental health provider workforce shortages.

As Congress works to address ongoing provider shortages that are especially acute in specialties like psychiatry, and to promote access to care in rural and underserved areas, the Committee should further prioritize workforce-building programs administered by the Health Resources and Services Administration (HRSA). Specifically, the Mental and Substance Use Disorder Workforce Training Demonstration Program which awards grants to institutions to support training for medical residents and fellows in psychiatry and addiction medicine who are willing to provide substance use disorder treatment and services in underserved communities. Likewise, the National Health Service Corps (NHSC) Loan Repayment Program for the Substance Use Disorder Treatment Workforce provides loan repayment for mental health professionals working in high-need communities or federally designated mental health professional shortage areas. Further investment in, and expansion of, both programs will help to encourage the recruitment, enrollment, and retention of students from disadvantaged backgrounds and shortage areas.

As we continue to build our workforce pipeline and as our healthcare system moves toward value-based integrated care, the most promising near-term strategy for providing prevention, early intervention and timely treatment of mental illness and substance use disorders is the implementation of evidence-based integrated care models using a population-based approach. The Collaborative Care Model (CoCM) is a proven integrated care model **and is the only model recognized by the Centers for Medicare and Medicaid Services (CMS)** with over 90 validated studies to show its effectiveness. The model provides mental health and/or SUD treatment in a primary care office through consultation between a primary care practitioner working collaboratively with a psychiatric consultant and a care manager to manage the clinical care of behavioral health patient caseloads.

The CoCM is population-based, which improves access by facilitating treatment for many more patients in comparison to usual one to one care. This is critical given the shortage of all mental health clinicians and is a useful way to quickly extend the current workforce and enhance access to care. This model allows patients to receive behavioral health care through their primary care provider in the primary care setting, alleviating the need to seek behavioral health services elsewhere. **The model is evidence-based and allows for the early diagnosis and intervention of mental health conditions in the primary care setting, which is important to prevent ER visits or hospitalization. Furthermore, the model uses measurement-based care, which means the patient's progress is tracked and treatment adjusted if indicated.** The model helps with the workforce shortage by leveraging the expertise of the consulting psychiatrist to be able to provide treatment recommendations on a panel of patients, generally 50-60 patients, for 1-2 hours a week. This is in contrast to seeing these patients 1:1, which we all know would involve longer wait times for an appointment.

Data shows that implementing the CoCM model has been shown to reduce a patient's depression symptoms by fifty percent. In addition, studies show the CoCM enhances access to care for patients in rural or underserved areas because the consultations between the team members are often done remotely, not face to face. The practical convenience and privacy in seeking care for mental illness in these settings may enhance help seeking by members of racial-ethnic minority groups. A study of African-American primary care users suggested that primary care settings could provide exposure to mental health services that familiarize people with mental health care, allowing African-American patients to "try before they buy."

CoCM is currently being implemented in many large health care systems and practices, and is also reimbursed by Medicare, several private insurers and numerous state Medicaid programs. Expanding the use of the CoCM will help improve access to mental health and substance use disorder treatment despite current workforce shortages, improve outcomes and health equity, and reduce health care costs. However, the requisite start-up costs have proven to be a barrier to its adoption by many practices. As such, APA **encourages the Committee to examine potential funding streams to assist with the implementation of the Collaborative Care Model in primary care offices.**

Parity

The Mental Health Parity and Addiction Equity Act (MHPAEA) requires that insurance coverage for mental health and substance use disorder services be no more restrictive than coverage for other medical care. However, many health plans are not in compliance with the requirements of MHPAEA despite the law having passed over ten years ago. Achieving full compliance with the parity law's requirements is essential given the need to access and maintain coverage for mental health and substance use services, especially with the increase in deaths from drug overdoses and suicides during the COVID-19 pandemic. As a follow-up to changes to the law which strengthened the MHPAEA and were included in the December 2020 Consolidated Appropriations Act (CAA), **APA supports provisions levying civil monetary penalties on health plans, issuers and third-party administrators found to be in violation of parity law requirements. These provisions were also supported by the previous Trump Administration and the current Biden Administration.**

The 2020 CAA also required federal agencies to request a certain number of comparative analyses from insurance plans and insurers each year demonstrating their compliance with the existing provisions of the MHPAEA law**. According to the report issued on January 25, 2022 by the Departments of Labor, Health and Human Services and Treasury**, the federal agencies requested 171 comparative analyses from insurers, and found that upon initial examination, not a single analysis contained sufficient information. Additionally, throughout the process of collecting supplemental information, the agencies found numerous parity violations potentially affecting millions of beneficiaries. The report validates concerns that insurance plans and insurers are still not fully compliant with the federal parity law and more transparency and accountability is needed. **APA thus encourages the Committee and Congress to support policies that would bring insurers into compliance with MHPAEA immediately. It is also vital that Federal and State agencies receive the resources necessary to enforce the law and hold insurance plans and issuers accountable.**

Further, parity requirements should also be added to Medicare, since Medicare beneficiaries are not protected by MHPAEA's anti-discrimination protections that apply to Americans with most other types of insurance coverage (except for the very rare examples of Medicare Advantage plans provided through an employer-sponsored plan). That means that many of those with the most severe mental illnesses are not protected by MHPAEA and do not receive the mental health or substance use disorder care they need. Not only is this a major shortcoming that harms those 65 and older, but it is also a serious barrier for the nine million Americans who have Medicare coverage because of their disability status. **Congress could address this by applying the federal MHPAEA law to Medicare Parts A through D and ensuring that Medicare covers specific mental health and SUD benefits that it now excludes**.

Psychiatric Beds

Multiple factors contribute to the boarding of psychiatric patients in the emergency room, ranging from societal challenges and hospital-system issues to individual patient characteristics. Though the most frequently cited cause of emergency room boarding is the shortage of psychiatric inpatient beds, the issue is more closely related to insufficient funding of lower

levels of care. These underfunded community clinics, intensive outpatient programs, community crisis stabilization units and respite services are inadequate to meet massive demand for psychiatric services at a lower level, and sadly force patients to wait until they reach crisis levels and must seek care in the emergency setting.

A 2016 membership survey conducted by the American College of Emergency Physicians found that seventy five percent of respondents saw patients at least once a shift or several times a shift who require admission for mental illness. The same survey also found that ninety percent of respondents had psychiatric patients boarding in their emergency departments, with patients waiting in the emergency department ranging from just a few hours to more than ten days for some to find an inpatient bed. Most respondents indicated that they were seeing increased wait/boarding times during that time as well. Further adding to the strain to the health system is the cost of boarding, with the average cost to an emergency department to board a psychiatric patient estimated to be around $22,642. In addition, according to Crisis Now, a crisis services advocate coalition led by the National Association of State and Mental Health Program Directors, estimated that the cost of not matching patients to their care needs is about $2,264 per psychiatric patient.

Moreover, psychiatric patients may require increased use of ancillary support (such as security officers or safety attendants), especially if they are agitated and because they have a statistically increased elopement risk. Boarding also results in emergency room inefficiency, increased rates of patients who leave without being seen, longer inpatient stays for admitted patients, as well as lost revenue and consumption resources.[1] In order to help alleviate the shortage of psychiatric beds, we need to invest more heavily in lower levels of care as mentioned above, and adequately fund and implement crisis services at the state and local levels. Finally, it is also important that Congress eliminate the IMD exclusion on state, for-profit, and not-for-profit facilities while maintaining the maintenance of effort. In addition, eliminating the 190-day lifetime limit for psychiatric hospitals and applying the mental health parity law to Medicare, as detailed above.

The 988 Lifeline and Continuum of Crisis Care Services

The passage of the National Suicide Hotline Designation Act in 2020 was an important step in reimagining crisis response for everyone, regardless of location or background. The creation of a new three-digit number (988) for suicide prevention and other mental health crises will make it easier for those experiencing a mental health emergency to reach out for help. While 988 is expected to support millions of people each year who face a mental health, suicidal, or substance use crisis, important work remains to ensure those utilizing the line receive the response and care they need.

Most communities have limited or poor options when it comes to services that support someone in a behavioral health crisis, with law enforcement and hospital emergency departments forced into being the de-facto responders. The result is a system stretched exceedingly thin, with delays in treatment, excessive costs, and the unnecessary criminalization of many with mental illnesses. As the new three-digit crisis code becomes universally available,

establishing the foundations of crisis management, comprehensive community services, educational resources, specialized care, and effective infrastructure, will be imperative.

The 988 call system holds great promise for offering all people facing mental health or substance use emergencies the appropriate support, services, and responses to get care and treatment. But that can't happen until states and the federal government roll it out effectively. If some states aren't prepared to launch 988, or have weaker infrastructure or support for it, the resulting patchwork will perpetuate inequities in mental health access rather than reduce them. States are largely responsible for implementing the crisis line, including building the infrastructure, training staff, and integrating it with 911 and other emergency services, but lack the federal and state resources to do so. As a result, only a handful have taken substantive action towards building out a functioning and sustainable 988 system, and more than half the states haven't made any progress at all. Consequently, we will have a patchwork of systems throughout the US, resulting in many persons who need the are not getting it.

To ensure that states and local communities are prepared for the July launch of 988, continued and increased congressional support for the Substance Abuse and Mental Health Services Administration (SAMHSA) to help build awareness and provide federal funding and technical assistance through mechanisms like the mental health block grant will be key as well as Medicaid's newly enacted opportunities to implement mobile crisis funding. It is essential that Congress and the states support the full continuum of crisis response—regional crisis call centers, mobile crisis response teams, and crisis receiving and stabilization facilities. It is essential that patients in crisis have a safe place to go to receive care that will accept them anytime, day or night. Building a robust crisis response system will depend on implementing the full continuum of best practices supported by SAMHSA and the Crisis Now model developed by the National Alliance on Suicide Prevention.

I thank you for the attention to the mental health needs of our patients across the country. I am encouraged by the bipartisan, bicameral support we're seeing from Congress and in particular this Committee with regards to addressing our most pressing mental health and substance use disorder needs. Finally, I thank you for extending me the opportunity of testifying before you here today and look forward to both hearing my colleagues on the panel testify and to answering each of your questions.