

Testimony: House Labor, Health and Human Services, Education Appropriations Subcommittee
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Good morning and thank you Chairwoman DeLauro, Congressman Cole, and distinguished members for the opportunity to speak today. My name is Verna Foust and I am the CEO of Red Rock Behavioral Health Services, a Community Mental Health Center and Certified Community Behavioral Health Clinic (CCBHC) in Oklahoma serving 18 urban and rural counties with 26 locations. I have worked closely with my State's alcohol and drug agency, the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS), for many years. The State agency plays a critical role in overseeing the publicly funded substance use service system. One of the benefits of making federal funds, such as the Substance Abuse Prevention and Treatment Block Grant, available through the State alcohol and drug agency is the relationships it builds. The Agency understands what we do, holds us to high quality standards, and offers technical assistance as needed. The Substance Abuse and Mental Health Services Administration, or SAMHSA, administers many grants that benefit individuals struggling with addiction and prevent substance use and misuse from starting in the first place. We are grateful for SAMHSA's role as the lead federal agency for substance use and mental health issues, and hope that ongoing COVID relief efforts further bolster SAMHSA's role in administering critical substance use and mental health service grants.

Red Rock was one of the first agencies in 8 states to become a CCBHC under the federal planning and demonstration Program in 2017. Prior to the CCBHC initiative, recruitment and retention of staff were far more difficult, fee for service payment models did not allow for extensive consultation for complex cases, especially those with co-morbid conditions, and funding for robust crises services so desperately needed were not in reach.

The CCBHC model changed all of this. It has significantly improved access to care and clinical quality. The proven success of this program has led to Congress repeatedly extending the demonstration and appropriating over \$1.5 billion dollars for the expansion of the program since 2018. Today there are 340 CCBHCs in 40 states, Washington, D.C. and Guam.ⁱ I have worked in community mental health for over 30 years. The CCBHC model is a lifeline for those served and for the serving agencies. CCBHCs provide services to the entire communities they serve regardless of ability to pay. Most people served are living impoverished with a higher rate of physical and mental health conditions. What's more, the CCBHC model provides integrated care coordination for physical health, mental health and addiction treatment in an effort to move the needle on the fact that Americans with severe mental and addiction disorders die 10 - 25 years earlier than the general population,ⁱⁱ typically due to untreated chronic medical conditions such as cardiovascular disease, respiratory and infectious diseases, diabetes, and hypertension.ⁱⁱⁱ

This model of integrated care is the linchpin of the CCBHC model. However, this desperately needed model will end on September 30, 2023 for states in the CCBHC demonstration unless Congress extends the program. In my opinion, extending and supporting the CCBHC model to all 50 states and territories could be the single most significant factor in greatly improving access, quality of care and the coordination of mental and physical health to save the lives of those with severe mental illness and addiction. It is incredibly beneficial to providers when we know that grant funds will be available well into the future; having funding allotted for only one or two years at a time makes it more difficult to plan.

There has been a shortage of mental health professionals in the US for many decades, particularly in rural areas. The National Survey on Drug Use and Health has consistently shown that the majority of those in need of treatment for mental and substance use disorders are not

served; 56.5% of adults with a mental illness and 64.1% of youth with major depression do not receive any mental health treatment.^{iv} In 2018, there were 67.9 million Americans with mental and/or substance use disorders including about 2.4 million adolescents aged 12 to 17 who had a Major Depressive Episode with severe impairment within the past year.^v Individuals from racial and ethnic minority groups are half as likely to receive treatment as non-Hispanic White people.^{vi} This lack of treatment has resulted in our prisons and jails becoming the new institutions to house people with mental health and addiction disorders.

There are many reasons for the mental health and addiction workforce shortage, especially for publicly funded agencies like ours. Wages and benefits are low, the paperwork is a heavy burden, and the incredible stress of trying to help very ill adults and children with very complex issues often leads to burnout. Over time, especially for therapists seeing children, they often experience vicarious trauma from their clients' horrific stories of abuse and neglect.^{vii}

While the demand for care is rapidly growing, the number of mental health professionals is barely holding even.^{viii} A 2016 report by the Health Resources and Services Administration projects a shortfall of 250,000 mental health professionals by 2025.^{ix} We simply have to increase the workforce to meet the demand.

There are several ways to improve the shortage of mental health professionals. The CCBHC model is a great start. CCBHCs benefit from a daily or monthly payment model based on a cost report that allows reimbursement for the true cost of the service. This allows for higher salaries to employ and retain mental health and addiction professionals. Another helpful strategy would be broader access to student loan repayment. While the HRSA National Service Corps does allow mental health professionals' student loan repayment in national shortage areas,

broadening the benefit to all CCBHCs regardless of geographic areas, as is available for all FQHCs, would be a significant help in recruitment and retention.^x

I have worked in community mental health for over 30 years. I have seen a lot of changes over the decades but the current level of acuity in adults and children being seen in our community clinics is far more severe and prevalent than I have ever seen. Since COVID, according to the Center for Disease Control and Prevention, the rate of young adults age 18-24 that have seriously considered suicide in the last 30 days has increased from 10% in 2018 to over 25% in 2020.^{xi} The Disaster Distress Helpline operated by the federal government saw an 880% increase in calls and a 1,000% increase in texts.^{xii} A quote from Michelle Williams, Dean of Harvard Chan School, states it well: “The past year has been terribly damaging to our collective mental health. There is no vaccine for mental illness. It will be months, if not years before we are fully able to grasp the scope of the mental health issues born out of this pandemic. Long after we’ve gained control of the virus, the mental health repercussions will likely continue to reverberate.”^{xiii}

The pandemic has affected many people’s mental health especially for those already suffering. About four in 10 adults in the U.S. report symptoms of an anxiety or depressive disorder, compared to one in ten adults who reported these symptoms in 2019 before the pandemic.^{xiv}

The December 2020 COVID-19 relief package included an investment of \$1.65 billion for the Substance Abuse Prevention and Treatment (SAPT) Block Grant. Considering the impact that the pandemic has had—and will continue to have for years ahead—on substance use disorders, these Block Grant dollars are vital. We are very appreciative of the work this Subcommittee has done to include supplemental funding for the Block Grant, as those dollars

will help ensure that individuals get the care that they need. A bright light during the pandemic has been Congress' approval to provide services to Medicare and Medicaid recipients through the use of Telemedicine. CCBHC funding had allowed us to increase and improve technology and develop a larger workforce so that the necessity to move to virtual services quickly was practically seamless. Clinicians quickly embraced this technology and have become skilled providers. We have also seen how patients have embraced this model. Other benefits include the ability to be seen more quickly in the privacy of their home. For many people, their fear of seeking treatment adds to the stigma of going into a clinic. Telemedicine is particularly valuable for those in crisis who need quick access to care. While telemedicine is not appropriate in some circumstances, I urge Congress to permanently allow the use of Telemedicine for Medicare and Medicaid recipients for the reasons just noted. We hope that any further federal efforts to address the pandemic's long-term impact on addiction issues will take into account the benefits of multi-year investments. Providers benefit from being able to plan with certainty, and knowing that funding will be available beyond a one-time allotment allows us to hire staff and expand service delivery with a sense of financial security for the years ahead.

In summation, the federal block grant to the states is critical to provide services to the vulnerable. The CCBHC model is transforming our system. It has resulted in improved access to care, high quality treatment through the use of evidence based practices and staff training, enhanced care for veterans, and is saving lives through the coordination of mental and physical health care. We must quickly address the workforce shortages to keep up with the increasing demand so desperately needed, and understand that COVID has had a significant and lasting impact on the mental health of Americans.

Again, thank you for this opportunity.

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