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Statement for House Labor-HHS-Education Appropriations Subcommittee – May 19, 2021

Chairwoman DeLauro, Ranking Member Cole, and Members of the Subcommittee, on behalf of the National Alliance on Mental Illness, thank you for the federal investments in mental health crisis response that you have supported and made possible so far. I appreciate the opportunity to discuss NAMI's priorities, many of which we share, as evidenced by the hearing this Subcommittee held last week on building a robust crisis response system. Without personnel who are trained to handle mental health emergencies, and without the infrastructure in place, the default response to many people in crisis is a law enforcement response, which often ends in trauma or tragedy. In fact, one in four fatal police shootings are of people with mental illness, with one in three being people of color. The lack of effective crisis response also burdens emergency departments (EDs) that are ill-equipped for mental health crises, despite the fact that one of every eight ED visits is related to a mental health or substance use disorder. But as you said in your statement, Madame Chairwoman, there is something we can do about it. Thank you for your leadership.

NAMI is grateful that Congress passed the bipartisan National Suicide Hotline Designation Act of 2020, which created 988 as a three-digit mental health and suicide crisis line that will go live nationwide by July 16, 2022. This alternative to 911 gives communities the opportunity to transform care by developing 988 crisis response systems with the core elements described in SAMHSA's National Guidelines for Crisis Care: 1) crisis call centers, 2) mobile crisis teams, and 3) crisis receiving and stabilization programs. Crisis call center hubs, staffed by people well-trained in crisis response, can assist the vast majority of people calling with a

behavioral health crisis. For those who need more, mobile crisis teams provide an in-person response and are able to effectively de-escalate the majority of behavioral health crises and connect people to follow-up services. In situations where needs are more acute, crisis receiving and stabilization services provide safe, therapeutic settings that reduce reliance on ED visits and can avoid the need for hospitalization.

While there is a clear vision for successful 988 crisis response systems, few systems meet the standards needed to realize this vision. Currently, National Suicide Prevention Lifeline (Lifeline) call centers rely on a patchwork of inadequate funding, leaving insufficient capacity to meet current needs, let alone the increased demand that will be spurred by the adoption of 988. There is growing availability of mobile crisis teams, but demand still far outstrips supply, particularly for children and adolescents. There is a dearth of crisis stabilization programs nationwide, and widespread shortages of behavioral health professionals to staff crisis response systems.

Robust federal investment is required to realize the promise of 988 to deliver a mental health response to mental health crises. Some states are adopting 988 user fees, but those fees are minimal and will support only a portion of 988 crisis system costs. Medicaid rarely covers the full costs of the core services—and it does not cover services for people who are not Medicaid-eligible. Without federal support, communities will be unable to develop and sustain a crisis infrastructure that ensures a mental health response will be available for mental health crises.

To help communities develop capacity for the critical first element of a 988 crisis system, crisis call center response, NAMI strongly recommends including $240 million in FY2022 for the National Suicide Prevention Lifeline. This recommendation is based on an initial analysis from Vibrant Emotional Health, the current administrator of the Lifeline. This will provide

needed funding to expand capacity for 988 calls, chats, and texts, including implementing technology, enhancing standards and training, and providing nationwide back-up for local call centers.

In FY2021, this Subcommittee included an additional $35 million in the Mental Health Block Grant to fund a 5% set-aside for Crisis Care Services. While this was a valuable start and we are grateful for this investment that is helping states develop crisis services, especially mobile crisis teams, the need is substantial. That is why NAMI is requesting a 10% set-aside for crisis services in FY2022 to provide critical funds to both start up crisis services and to support the many costs of crisis care that are not covered by Medicaid or insurance plans.

NAMI is also requesting $12.5 million for the SAMHSA Strengthening Community Crisis Response Systems program. When someone experiences a mental health crisis, they often wind up in hospital emergency departments (EDs) where they frequently end up waiting in hallways, sometimes for days, before being admitted to an inpatient or residential facility. This practice, referred to as "ED boarding," is harmful to patients and strains already-burdened EDs. The $12.5 million we are requesting will help communities reduce the traumatic practice of ED boarding by providing intensive crisis services, such as crisis receiving and stabilization programs, and by implementing databases of beds at inpatient and residential behavioral health facilities that help reduce the wait for intensive treatment.

These three programs, while important, are only part of realizing the promise of a successful crisis response system. And while some of the needed investments fall outside this Subcommittee's jurisdiction, I believe it is important to give you the full picture of what is required to effectively implement a comprehensive 988 crisis response system over the next several years.

Whether through the annual appropriations process, broader efforts to upgrade our country's infrastructure, or other means, Congress must invest $10 billion over the next 10 years in 988 infrastructure in three key areas: 1) Supporting capital projects and operations, 2) Increasing the behavioral health workforce, and 3) Ensuring Medicare, Medicaid, and TRICARE coverage. I would like to give you a quick overview of what is needed in each area.

First, supporting 988 capital projects and operations. To build a mental health crisis system that relies on well-equipped 988 call centers as the first point of contact, federal support of the national Lifeline should be supplemented by federal authorization and funding, based on SAMHSA's projections, to support operations at 180+ local Lifeline call centers across the country. This will ensure that people get connected to services when and where they need them.

In addition, communities need support for capital expenses to expand crisis services, such as mobile crisis team vans, facilities for crisis receiving and stabilization and peer respite programs, and call center infrastructure. Congress should expand funding and broaden the uses of the Health Resources and Services Administration's (HRSA) current Capital Development Grants to include crisis system infrastructure.

Second, increasing the behavioral health workforce. As the Subcommittee knows, behavioral health workforce shortages pose challenges for health systems, including crisis response. Congress can help by significantly expanding behavioral health workforce training programs, including HRSA's Behavioral Health Workforce Education and Training (BHWET) and Graduate Psychology Education (GPE) programs, as well as SAMHSA's Minority Fellowship Program (MFP). In addition, to help recruit and retain skilled staff, HRSA's National Health Service Corps Loan Repayment Program criteria must be expanded to include crisis call

centers, mobile crisis teams, crisis receiving and stabilization programs, and Certified Community Behavioral Health Clinics.

Third, ensuring Medicare, Medicaid, and TRICARE coverage of crisis services. It is also vital that Medicare, Medicaid, and TRICARE cover mobile crisis and crisis stabilization services. Together, these programs cover tens of millions of people, many of whom will experience mental health and suicidal crises and deserve an appropriate response. Peer support specialists in particular play critical roles in crisis services yet are not covered providers under Medicare. That must change. Finally, to maximize access to behavioral health crisis services, Congress should make permanent the current flexibilities for Medicare coverage of telehealth behavioral health services.

It is NAMI's priority to ensure that an effective 988 crisis response system infrastructure is developed across the country and we are grateful for this Subcommittee's support. We recognize that it is also important to invest in research and a wide range of prevention, intervention, and recovery programs at SAMHSA, including Certified Community Behavioral Health Clinics, that help people get on a path of recovery. To that end, we urge your consideration of the Mental Health Liaison Group (MHLG) recommendations for FY2022 appropriations. NAMI also offers our strong support for the President's FY2022 proposed budget of $1.6 billion for the community mental health block grant and $1 billion to increase mental health professionals in schools.

Thank you for this opportunity and for the leadership you have demonstrated in advancing mental health care. I look forward to working with you to put in place the infrastructure to support a 988 crisis response system and transforming mental health care in America.