Attachment—Additional Questions for the Record

Subcommittee on Health
Hearing on
"High Anxiety and Stress: Legislation to Improve Mental Health During Crisis"
June 30, 2020

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The Honorable Frank Pallone, Jr. (D-NJ):

Parity in Mental Healthcare

H.R. 5469, the Pursuing Equity in Mental Health Act of 2019, would authorize grants targeted at high-poverty communities for culturally and linguistically appropriate mental health services. The bill would also provide support to encourage more students of color to enter the mental healthcare workforce, among other things.

1. Dr. Evans, can you put these solutions into context and describe how minority fellowship programs play a role in reducing inequities?

As I highlighted during my testimony, we are currently in a "syndemic" that exacerbates the impact of COVID-19 by contributing to disease clustering among those already at higher risk for poor health. As we know from the data, COVID-19 is spreading more rapidly amongst under-resourced areas that are the product of longstanding social inequality and injustice. We also know that public health messages such as staying at home, washing hands, COVID-19 symptoms and testing, physical distancing, and uses of technology do not reach all populations that have been disproportionately affected by COVID-19. Additionally, we know that approximately one-third of all COVID-19 related deaths have come from people residing in nursing homes and other long-term care facilities.

The Minority Fellowship Program (MFP) is currently the only federal program that funds trainees in psychology, psychiatric nursing, social work, psychiatry, and marriage and family therapy, as a means of promoting culturally competent mental health services for ethnic minority populations. The disproportionate impact of COVID-19 on communities of color continues to have serious mental health implications long after the current pandemic has subsided. Addressing mental health care disparities, particularly amongst community of color, will require a sustained, coordinated, long-term effort from both Congress and the Administration and a workforce to match the increased demand for mental health services. As such, we have

recommended the passage of the Pursuing Equity in Mental Health Act to, among other measures, fund stronger support for the Minority Fellowship Program (MFP).

APA's Stress in America survey[1], released earlier this month, found heightened concern and anxiety, particularly amongst adults without children and communities of color, about the largest issues currently facing our society. 78% of Americans said the COVID-19 pandemic was a significant source of stress. 55% of Black adults said discrimination was a source of stress – an increase from 42% just one month ago. Reported stress is driven by a number of factors including meeting the basic needs of their families, such as food and housing access, and managing online learning. Investing in the Minority Fellowship Program is investing in urgently needed culturally competent care.

2. Dr. Evans, why is it important that the scientific workforce, as well as the clinical workforce, begin to reflect the racial and ethnic diversity of the U.S. population?

As I mentioned in my testimony, COVID-19 is worsening longstanding disparities in health status and outcomes. Social and economic inequality, discrimination, stigma, and marginalization are at the root of the differences we see among racial and ethnic minorities. These factors, combined with higher risks for chronic health conditions, make many communities of color more vulnerable to COVID-19. Many jurisdictions have reported higher rates and infections and deaths among racial and ethnic minorities. For example, according to the Louisiana Department of Health, while Blacks constitute only 32% of the total population, they constitute 70% of its COVID-19 related deaths.[2] In Chicago, Blacks account for 68% of the city's 118 deaths and 52% of the roughly 5,000 confirmed coronavirus cases, despite making up just 30% of the city's total population.[3] The CDC has also found disparities among patients hospitalized due to COVID 19; for example, in a catchment area with approximately 59% of while residents and 18% Black residents, among 580 hospitalized COVID-19 patients approximately 45% were white and 33% were black.[4]

Having a scientific and clinical psychology workforce that is as diverse as the community it serves represents a critical tool in boosting the profession's overall ability to provide culturally competent care. Research tells us that even when stigmatized groups can access care, a variety of factors – including providers' implicit biases – can contribute to a lower overall quality of care

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[1] American Psychological Association (July 2020), Stress in America 2020: Stress in the time of COVID-19, Volume Three. Retrieved from: https://www.apa.org/news/press/releases/stress/2020/report-july.
[2] The Louisiana Department of Health. (2020). Coronavirus (COVID-19). Retrieved from http://ldh.la.gov/Coronavirus/.
[3] City of Chicago. (2020). CHICAGO COVID-19 UPDATE. Retrieved from https://www.chicago.gov/city/en/sites/covid-19/home/latest-data.html and https://www.chicago.gov/content/dam/city/sites/covid/reports/2020-04-08/Chicago%20COVID19%20Update%20V2%204.8.2020.pdf.
[4] United States Department of Health and Human Services, Centers for Disease Control and Prevention. (2020). Morbidity and Mortality Weekly Report: Hospitalization rates and characteristics of patients hospitalized with laboratory-confirmed coronavirus disease 2019 – COVID-NET, 14 States, March 1-30, 2020.

and poorer outcomes for these groups relative to other patients. With a provider who is better trained in culturally competent care and has a better understanding of longstanding racial and ethnic disparities, patients are more likely to engage in mental or behavioral health treatment and build trust with their provider, resulting in better patient outcomes.

Mental Health in Children

The COVID-19 pandemic has posed a significant disruption on the daily lives of children. Over the past several months, children have had to stay home from school, extracurricular activities, and activities with friends while in social isolation. Many children are also suffering through the economic hardships experienced by their families, which, according to Substance Abuse and Mental Health Services Administration (SAMHSA), can either stimulate or worsen violence in the home. Research indicates that increased stress levels in parents is a predictor of abuse and neglect of children, and this problem is compounded by the lack of interaction with figures capable of recognizing and reporting such issues, such as teachers, counselors, or healthcare providers.

1. What impact have these challenges had on the mental health of children in this country?

Social isolation continues to have a significant impact on children, even in the absence of acute traumatic events. Many parents report that their children continue to face an array of social and emotional health challenges—including loneliness, anxiety, and depression—because of the COVID-19 pandemic. Many children are exposed to varying levels of trauma that may undermine their sense of safety and stability. A growing number of children face food insecurity and economic turmoil has undermined their home life. This trauma may have a long-term impact on their daily lives, including their ability to engage in learning.[5] Educators also recognize the enormous social and emotional toll of the pandemic on students. Recent surveys of teachers and administrators find that the mental health and well-being of both students and teachers is among their top priorities.[6] The shift to online schooling brought about not only learning-related challenges, but also challenges to the work of school psychologists and counselors, who have also shifted to providing their services remotely, often times in situations where needs have significantly increased and in areas where students lack internet connectivity.[7]

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[5] American Enterprise Institute. (2020). How parents are navigating the pandemic: A comprehensive analysis of survey data. Retrieved from: https://www.aei.org/multimedia/how-parents-are-navigating-the-pandemic-a-comprehensive-analysis-of-survey-data/.

[6] Educators for Excellence. (2020). Voices from the Virtual Classroom 2020: A Survey of America's Teachers on COVID-19-Related Education Issues. Retrieved from: https://e4e.org/sites/default/files/voices_from_the_virtual_classroom_2020.pdf; Teach Plus. (2020). Barriers to Bridges: Teacher Perspectives on Accelerating Learning, Leadership, and Innovation in the Pandemic. Retrieved from: https://teachplus.org/sites/default/files/downloads/Documents/teach_plus_barriers_to_bridges.pdf.

[7] American Psychological Association. (July 14, 2020). School psychologists adapt to help students during COVID-19. Retrieved from: https://www.apa.org/members/content/school-psychologists-covid-19.

2. How can disrupting children's educational and social routine affect their future performance in school or their ability to learn?

Because less than half of students are engaged in online schooling, we expect that pre-existing educational disparities will widen in the coming years without prompt intervention. Children from families with the resources and ability to provide support for online learning and enrichment will continue to develop to some degree, while others will likely experience learning losses that will accumulate over time.[8] With standardized testing currently on hold, there are no global measures available for obtaining baseline information on these disparities. Without this data, it will be difficult to design interventions to mitigate these disparities.

While some children may benefit from the absence of certain individualized triggers such as bullies, most will miss the social experience of academic and relational learning, which is especially important for young children. Additionally, many teachers have not yet gained sufficient experience in online teaching, which has a negative impact on student learning. Children who do not engage in online learning activities are that much more difficult to reach and more likely to be overlooked.[9] Additionally, children who depended on school-based mental and social services, as well as access to meals, will have a harder time concentrating and staying focused.

Extracurricular activities also serve some students with the opportunity to gain confidence that can transfer over to their schoolwork. School-supported enrichment activities such as bands, orchestras, theater clubs, sports, debate team or other social clubs also provide healthy outlets for a child's physical, academic, and creative pursuits, and their current absence stifles these productive outcomes and sense of identity.

3. What policy steps should Congress consider to mitigate the negative impacts of the COVID-19 pandemic on children's mental and emotional health?

APA recommends that Congress pass legislation that addresses the learning needs of students, while accounting for their emotional well-being. Such legislation could take a number of approaches to achieve this goal, including:

- Integrating social and emotional learning, promoting a healthy school climate, and integrating resiliency training throughout all areas of the curricula and ensuring these can be delivered in the event of a transition to hybrid/abbreviated school days or virtual schooling.

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[8] Tawnell D. Hobbs and Lee Hawkins, "The Results Are In for Remote Learning: It Didn't Work" The Wall Street Journal, June 5, 2020. Retrieved from: https://www.wsj.com/articles/schools-coronavirus-remote-learning-lockdown-tech-11591375078.

[9] Educators for Excellence. (2020). Voices from the Virtual Classroom 2020: A Survey of America's Teachers on COVID-19-Related Education Issues. Retrieved from: https://e4e.org/sites/default/files/voices_from_the_virtual_classroom_2020.pdf.

- Providing resources for schools to train educators and other school staff on the impact of adverse childhood experiences (ACEs) and traumatic experiences on children's health and development, and to implement trauma-informed practices in schools, including for teaching.

- Providing professional development resources for teachers that is personalized, contextual and translatable into practice to ensure learning continuity for in-person and virtual settings on topics including, but not limited to: social and emotional learning; culturally and linguistically responsive teaching; developing a healthy school climate; trauma-informed teaching; ACEs prevention and response; supporting unique learners; family engagement; implicit bias; and integrating technology.

As a critical first step towards this goal, APA recommends that Congress take the following specific actions:

- Increase funding for connectivity to broadband and high-speed internet, specifically at least $4 billion for the FCC's E-Rate Program;

- Pass H.R. 1109, the Mental Health Services for Students Act;

- Pass H.R 7859, the Strengthening Behavioral Health Supports for Schools Act;

- Increase funding for Project AWARE to $103 million in FY 2021; and

- Increase funding for Student Support and Academic Enrichment Block Grant (Title IV-A) to $1.2 billion in FY 2021.

Supporting Suicide Prevention Through a Lifeline

We know that rates of suicide were rising to alarming levels prior to the coronavirus pandemic. As we heard at our hearing, the distress caused by this public health emergency is only exacerbating what we knew.

A report from Well Being Trust estimates an additional 75,000 will die by suicide/death by despair as a result of this pandemic and about 4,000 of those deaths will be youth. Sandy Hook Promise's 24/7 crisis center, which receives reports from schools and students across the country, has seen over a 10 percent increase in suicide tips.

1. Is a convenient call number an effective way to help in suicide prevention? What are other important ways Congress can support suicide prevention?

An easy-to-remember, three-digit 9-8-8 number for the National Suicide Prevention Lifeline, as supported by the National Suicide Hotline Designation Act (S.2661/H.R. 4194), would serve as an effective means to further national suicide prevention efforts by making mental health

services readily available. The American Psychological Association is a strong supporter of the bipartisan, bicameral bill and urges Congress to enact the legislation without further delay.

We also recommend that Congress strengthen funding for the Farm and Ranch Stress Assistance Network program authorized in the 2018 farm bill. This network supports critical programs, including but not limited to helplines and websites, training programs and workshops, and outreach services, to reduce the risk of suicide amongst farmers, ranchers, farmworkers, and other agriculture-related occupations.

The need for effective suicide prevention measures is especially felt amongst the veteran community, which experiences higher overall suicide rates than the general population. Additionally, according to a 2019 study[10] by the VA Office of Mental Health and Suicide Prevention, 69.4% of veteran suicide deaths are attributable to firearms, compared to only 48.1% of non-veteran suicide deaths. To protect veterans and other individuals at risk of suicide, it is essential that policies concerning access to lethal means of self-harm, including safe storage of firearms, are included in any discussion around suicide prevention.

In addition to robust funding for existing federal suicide prevention programs, such as Project AWARE for school-aged youth, Congress can enact the following bills to help save lives and promote early intervention:

- The Suicide Prevention Lifeline Improvement Act (H.R. 4564), to increase funding for the National Suicide Prevention Lifeline and develop strategies to help ensure evidence-based care, data sharing and innovative technology programs.

- The Campaign to Prevent Suicide (H.R. 4585), to serve as an important public awareness campaign for the new 9-8-8 number and help change the culture around suicide to promote engagement rather than avoidance in people who need help.

- The Mental Health Services for Students Act (H.R. 1109/S. 1122), to establish on-site mental health care services for public schools across the country.

- The Suicide Prevention Act (H.R. 5619), and the Effective Suicide Screening and Assessment to the Emergency Department Act (H.R. 4861/S.3006), to provide emergency departments with suicide screening and assessment tools.

- The Suicide Training and Awareness Nationally Delivered for Universal Prevention Act (H.R. 7293/S.2492), to implement student suicide awareness and prevention training policies.

[10] U.S. Department of Veterans Affairs, Office of Mental Health and Suicide Prevention (2019). 2019 National Veteran Suicide Prevention Annual Report. Retrieved from: https://www.mentalhealth.va.gov/docs/data-sheets/2019/2019_National_Veteran_Suicide_Prevention_Annual_Report_508.pdf.

The Honorable Doris Matsui (D-CA):

Currently, there is no complete, timely source for monitoring suicide attempts in the United States.

I believe there is an opportunity to leverage data to save lives here, that is why I have introduced with Rep. Stewart the Suicide Prevention Act, a bipartisan and bicameral proposal that will help to identify and track suicide attempts and instances of self-harm in emergency departments.

1. Dr. Evans, why is the surveillance of suicide attempt visits to emergency departments important, and what can Congress do to support data collection to help address this ongoing crisis?

The American Psychological Association appreciates the Suicide Prevention Act (H.R. 5619) introduced by Rep. Matsui and Rep. Stewart, as well as the effort to help track self-harm and suicide attempts in hospital emergency departments (EDs). Improving surveillance for suicide in EDs, and hiring and training relevant staff, is essential for monitoring and applying preventive strategies to help prevent suicide attempts and deaths by suicide in patients after their discharge from hospitals. A patient's history of a suicide attempt is a known risk factor for a completed suicide. Although most who attempt suicide will not go on to die by suicide, many people who die by suicide have made a previous attempt.

Research has shown that when ED personnel screen all patients for suicide, regardless of the reason the patient presented to the ED, the number of patients identified as having suicidal ideation or a history of a past attempt doubled[11]. According to this study, an estimated 10,000 at-risk individuals could be identified each year at the eight hospitals that participated in this study alone. Scaled up nationwide, expanding ED screenings could identify over 3 million adults at risk for suicide. Additional research has shown that pairing ED screenings with safety planning and post-discharge telephone follow-up calls resulted in a 30 percent decrease in suicide attempts over the course of one year[12]. Further research demonstrated the cost-effectiveness of such post-discharge interventions, including follow-up postcards, phone calls, or cognitive-behavioral therapy[13]. The evidence highlights the value of expanding the surveillance of patients who come through EDs by trained personnel, and following up with those patients post-discharge, as a way to try and decrease deaths by suicide.

The Honorable Nanette Diaz Barragán (D-CA):

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[11] Boudreaux ED, Camargo CA Jr, Arias SA, et al. Improving Suicide Risk Screening and Detection in the Emergency Department. *Am J Prev Med*. 2016;50(4):445-453. doi:10.1016/j.amepre.2015.09.029

[12] Miller IW, Camargo CA, Arias SA, et al. Suicide Prevention in an Emergency Department Population: The ED-SAFE Study. JAMA Psychiatry. 2017;74(6):563–570. doi:10.1001/jamapsychiatry.2017.0678.

[13] Denchev P, Pearson JL, Allen MH, et al. Modeling the Cost-Effectiveness of Interventions to Reduce Suicide Risk Among Hospital Emergency Department Patients. Psychiatr Serv. 2018;69(1):23-31. doi:10.1176/appi.ps.201600351.

1. I know parity laws exist to prohibit health insurance plans from imposing less favorable benefit limitations on mental health and substance use disorder treatment. However, I am concerned that limitations may still exist. For instance, I have heard of individuals being limited in the number of visits they can have with a mental health professional over the course of a year. How common is the situation I described, and if people who need to speak regularly with a mental health professional have limited access, what are the potential negative consequences?

The Mental Health Parity and Addiction Equity Act (MHPAEA) has greatly improved patients' access to mental health care in some areas. Prior to the enactment of this law, it was very common for plans to have hard annual limits of 30, 40 or 52 sessions per year. However, problems still remain, as many plans limit the number of sessions with "softer" non-numerical limitations. In particular, plans frequently cut off care, arguing that further sessions are no longer "medically necessary." In some cases, plans' medical necessity determinations are arbitrary and/or discriminate against patients seeking mental health services. These abuses are more difficult to address because they fall under the complex and subjective parity analysis for non-quantitative treatment limits (NQTLs)[14].

The evidence is clear that early treatment of mental and behavioral health conditions is a critical factor in securing a better patient outcome, and delayed or terminated treatment can not only lead to a higher personal cost to the patient—such as worsening symptoms of anxiety or depression, or even suicide—but also to higher downstream societal costs, such as increased use of emergency rooms for crisis care. Time and again, we hear stories from our members who describe how unnecessary barriers to care led even minor symptoms of anxiety or depression to quickly escalate into a major mental health crisis.

APA is proud to have been a leader in fighting for the passage of this landmark law, but we realize that there is much work to be done. APA has led the effort over the past 11 years to push for implementation and enforcement of MHPAEA, as well as improvements to the underlying law. We would be happy to talk with you further about our thoughts on how to strengthen MHPAEA and bring the nation closer to the ideal of equal access to mental health care.

The Honorable Lisa Blunt Rochester (D-DE):

1. I'm a cosponsor of H.R. 7080, the Stopping Mental Health Pandemic Act, which will help address behavioral health needs caused by COVID-19, including supporting outreach to underserved and minority communities. Can you discuss mental health stigma among communities of color?

[14] This analysis is not only complex but also highly subjective and suffers from a lack of transparency, complicating the ability of patients and stakeholders to determine if there is a MHPAEA violation and argue against abusive practices. NQTLs also limit mental health care in other important ways, such as plans that reimburse for mental health care at lower rates, resulting in inadequate plan networks.

Stigma associated with accessing mental health care persists in minority communities. Addressing the persistent stigma around mental health is a vital step to increasing utilization of reducing behavioral health services by these populations. Decades of research show bias, stigma and discrimination are associated with poorer physical and mental health outcomes among racial and ethnic minorities and other marginalized populations. Negative attitudes and beliefs toward people who have or are perceived to have mental illness are not uncommon and have long been recognized as barriers to seeking mental health treatment. Stigma may also result in people with mental or behavioral health needs hiding symptoms of their illness to avoid discrimination or social isolation. Some may not seek mental health care when needed.

In addition, stigmatized groups are more likely to be uninsured or underinsured, to have difficulty accessing cultural and language appropriate care, and to encounter provider bias and discriminatory in health care systems. Stigmatized groups are particularly vulnerable during public health emergencies. For example, stigma also worsens well-documented health inequities that the coronavirus has vividly exposed in recent months. An APA resource[15] provides more information on this topic.

As I referenced in my testimony, APA supports a population health approach that tailors a system of care to the needs of particular populations, examines the distribution of health and social determinants of health across populations, and focuses attention on the need to provide access to evidence-based treatment for those in need of clinical intervention. If implemented, such an approach would improve mental health for the entire population, thereby improving lives and reducing the cost burden on our health-care system by placing greater emphasis on intervention before people are in crisis.

Accordingly, APA supports the Reducing Mental Health Stigma in the Hispanic Community Act of 2019 (H.R. 4543), which would provide for a behavioral and mental health outreach and education strategy to reduce stigma associated with mental health among the Hispanic and Latino population. We also advocate for similar initiatives targeted to African American, Asian and Pacific Islander and Native American communities. Currently, we are reviewing the Stopping the Mental Health Pandemic Act (H.R. 7080).

2. In addition to supporting targeted outreach and education, what policies do you recommend that Congress focus on to close racial health disparity gaps in mental health?

In December 2019, APA submitted comprehensive recommendations to the Congressional Black Caucus Congressional Black Caucus (CBC) Taskforce on Black Youth Suicide and Mental Health in December 2019. Our recommendations to close racial mental health disparity gaps were to:

(1) Increase the federal investment in suicide prevention strategies tailored to Black children and adolescents;

[15] American Psychological Association. (2020). Combatting bias and stigma related to COVID-19. Retrieved from: https://www.apa.org/news/press/statements/combating-covid-19-bias.pdf.

(2) Expand access and availability to child and adolescent mental health services;

(3) Support public awareness campaigns and laws to encourage safe firearms storage;

(4) Enact policies to diversify the clinical and scientific behavioral workforce; and

(5) Strengthen data collection and research into youth suicide disparities.

APA also recommends expanding access to telehealth, including telehealth provided by an audio-only transmission, and increasing broadband access in rural areas and underserved neighborhoods. Finally, APA supports the Pursuing Equity in Mental Health Act (H.R. 5469) and the Evaluating Disparities and Outcomes of Telehealth During the COVID-19 Emergency Act (H.R. 7078).

3. You talked about all the barriers that have been removed for a variety of health care professionals in order for Americans to receive the medical care they need during the pandemic. You specifically mention that seniors are especially in need because of multiple chronic conditions associated with this demographic. For example, we know that the serious mental illness of eating disorders affects between 3 and 4% of seniors and are associated with chronic health conditions like Type I and II diabetes, osteoporosis, and heart failure. A recent report from Harvard University's STRIPED and Deloitte Access Economics has shown that late and untreated eating disorders cost the U.S. economy $64.7 billion per year. H.R. 3711, the Nutrition CARE Act, would provide outpatient coverage under Medicare for dietitian services for eating disorders called medical nutrition therapy (MNT). Do you think this bill fills a coverage gap that currently exists for the comprehensive treatment of eating disorders?

Yes. This legislation would provide access to essential nutrition care services under Medicare Part B for the comprehensive treatment of eating disorders. Nutrition represents a critical component of mental well-being; if an individual is not properly nourished, that person's mental acuity suffers, which can exacerbate the impact of other co-occurring mental health conditions and significantly impede recovery. However, MNT is not a covered benefit for outpatient eating disorder treatment under Medicare Part B. Eating disorders are mental health disorders that require a multidisciplinary team of mental health, nutrition and medical specialist (e.g., psychologist, psychiatrist, nutritionist, medical provider). A patient's inability to access the full suite of coverage provided for eating disorder treatment hinders their recovery.

4. If MNT is covered by Medicare, do you believe it will save the Medicare system money by addressing the illness early?

As noted above, in the recent report from Harvard University's STRIPED and Deloitte Access Economics, the economic impact on the U.S. economy as a direct result of eating disorders is $64.7 billion. This figure is staggering and illustrates the importance of prevention, early

intervention and comprehensive treatment for Americans. If MNT is covered for eating disorders at the outpatient level, the American Psychological Association believes there would be significant cost-savings to the Medicare system. Eating disorders have the longest average length of hospital stay (13.6 days) and the highest average cost ($19,400) out of any primary mental health diagnosis, and the need for robust comprehensive treatment at the outset is vital.[16]

5. How are Medicare beneficiaries at risk for isolation mental health issues as a result of the COVID-19 pandemic?

The COVID-19 pandemic is already having a negative impact on all Americans, as the data indicates a surge in COVID-related mental and behavioral health disorders—particularly anxiety, depression, and post-traumatic stress disorder. Nearly half of all Americans are reporting that the COVID-19 pandemic is having a negative impact on their mental health. The risk is especially prevalent amongst older adults or adults with disabilities enrolled in Medicare, particularly those in long-term care facilities who may experience isolation due to less frequent contact with friends or family to minimize the risk of infection. We have heard from our members about isolated patients confined to a hospital or nursing facility bed, whose family could not visit them due to COVID, leaving their only avenue of mental health support through talking on the phone with a psychologist.

Fortunately, Congress and the Administration have taken commendable steps to expand access to services furnished remotely via telehealth. As you know, these actions have drastically improved access to mental and behavioral health treatment, particularly to patients in remote areas or in communities that traditionally lack access to quality mental health care. Some patients report to our members that they feel more comfortable speaking to a psychologist by phone or by video, as opposed to the traditional office visit.

We applaud these recent steps to expand access to telehealth services during the COVID-19 pandemic, including a waiver of certain Medicare coverage requirements that limit coverage to patients in certain geographic areas and prevent coverage of mental health services furnished into the patient's own home. We also applaud the expansion of access to telehealth services furnished via an audio-only transmission, which was critical to reach Medicare enrollees who either reside in facilities that lack audio/video transmission capabilities or in geographic areas that lack access to broadband Internet. We hope that Congress continues to build on this momentum after the COVID-19 pandemic by making these changes permanent for behavioral and mental health services.

6. H.R. 945, the Mental Health Access Improvement Act of 2019, would provide for coverage of marriage and family therapist services and mental health counselor services

[16] Owens PL (AHRQ), Fingar KR (IBM Watson Health), McDermott KW (IBM Watson Health), Muhuri PK (AHRQ), Heslin KC (AHRQ). Inpatient Stays Involving Mental and Substance Use Disorders, 2016. HCUP Statistical Brief #249. March 2019. Agency for Healthcare Research and Quality, Rockville, MD. Retrieved from: www.hcup-us.ahrq.gov/reports/statbriefs/sb249-Mental-Substance-Use-Disorder-Hospital-Stays-2016.pdf

under Medicare. What role can mental health counselors and marriage and family therapists play in address mental health issues as a result of COVID-19?

Marriage and family therapists and mental health counselors are licensed as master's level mental health professionals in all U.S. jurisdictions, under slightly varying titles. Consistent with the scope of practice delineated in state licensure laws and their personal areas of competence and expertise, they can provide basic counseling and therapy services, referring more complex cases to other mental health professionals. The COVID-19 public health emergency, combined with the social isolation and loneliness that the response to the pandemic has required, is significantly increasing the prevalence of depression and anxiety, and leaving millions of Americans in poor mental health.