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

Hon. Patrick J. Kennedy
Founder
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The Honorable Frank Pallone, Jr. (D-NJ):

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. Given your work in suicide prevention, would a convenient call number be an effective way to provide help? If so, can you describe why you believe that to be the case?

Answer:

The National Suicide Prevention Lifeline (1-800-273-8255) provides 24/7, free and confidential emotional support to people in suicidal crisis or emotional distress. The Lifeline, administered by the nonprofit Vibrant Emotional Health and funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), consists of an expansive network of over 170 independently operated local and state-funded crisis centers across the U.S. The Lifeline is effective in reducing suicidal and emotional distress, and in 2020, is estimated to reach 2.5 million people.

But individuals experiencing mental health or suicidal crises need easier access to the Lifeline. 9-8-8, an easy-to-remember three-digit dialing code for mental health emergencies, would help people in crisis more seamlessly access lifesaving resources. Recent reporting from the Centers for Disease Control and Prevention (CDC) indicates that mental health and suicidal ideation has worsened since the onset of COVID-19.

The bipartisan National Suicide Hotline Designation Act (S.2661) would help ensure access to

an easy-to-remember, three-digit line directly to trained counselors. The bill would provide states with critical funding guidance to stand up the new three-digit dialing code. It would also provide for critical federal reporting and specialized service training. Specifically, the bill asks SAMHSA to create an implementation plan for providing enhanced services for at-risk populations, including LGBTQ youth.

We are grateful for the House's identical version of the bill, H.R. 4194, being approved by the Energy & Commerce full Committee but it is still waiting on floor consideration. Given the FCC already began the two-year implementation timeline and the Senate passed S. 2661 months ago, the House now needs to take up S. 2661 as quickly as possible in order to ensure the 988 Lifeline Network is properly funded and able to provide the highest level of care possible.

Designating 9-8-8 as the universal telephone number for a national mental health crisis and suicide prevention hotline system maintained through SAMHSA and VA would save lives. If Congress does not act, the vision of 988 as a robust crisis intervention resource that serves more people in emotional crisis will not be met, and lives could be lost.

The Honorable Nanette Diaz Barragán (D-CA):

1. In your testimony, you mentioned a survey conducted by the California Policy Lab that found that nationally, half of unsheltered individuals said a mental health disorder was a major factor in them becoming homeless. Homelessness is a huge problem in Los Angeles including in and around my district. If only we put more resources into mental health treatment, we could also help reduce the rate of homelessness in this country. Can you please elaborate on the part of your testimony discussing the connection between mental health conditions and homelessness, and what recommendations do you have for Congress to help us tackle this issue?

Answer:

As I noted in my written testimony, untreated mental health and/or substance use disorders are a major contributor to homelessness. Without early treatment, many individuals' conditions deteriorate, too often resulting in loss of income, disability, and unemployment. For instance, depression is the leading cause of disability for people ages 14 to 44.[1] Early-onset severe mental illness is associated with lower quality of life, increased mortality, a 24-percent increase in medical spending, and a 48-percent decrease in lifetime earnings. Together, these poor outcomes contributed to $1.85 *million* in lifetime economic burden per patient.[2] According to a systematic

[1] Stewart, W. F., Ricci, J. A., Chee, E., Hahn, S. R., & Morganstein, D. (2003). Cost of lost productive work time among US workers with depression. Journal of the American Medical Association, 289, 3135-3144.
[2] Measuring the Lifetime Costs of Serious Mental Illness and Mitigating the Effect of Educational Attainment, Health Affairs 38, No. 4 (2019): 652-659.

review and meta-analysis of mortality among people with mental health disorders, the median decrease in life expectancy associated with serious mental illness is 10 years.[3]

Thankfully, initiatives such as the Mental Health and Suicide Prevention National Response to COVID-19, which I co-chair with Dr. Joshua Gordon, director of the National Institute of Mental Health, are working on recommendations to create a system that prioritizes prevention and early intervention. The recommendations below are consistent with those being considered by these initiatives.

Ensure First Episode Psychosis treatment. Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP) can be very successful at reducing (even sometimes eliminating) further episodes of psychosis associated with schizophrenia or another mental illness. CSC has been found to decrease hospitalization, increase employment and education rates, and improve social functioning.[4] [5] Tragically, as noted by NAMI, treatment for psychosis usually starts "long after the first episode and after disability has taken hold." It notes that even when treatment does begin, it "is often limited to managing symptoms rather than promoting full recovery."[6] Hence, treatment immediately upon FEP is critical, particularly given the estimated cost of schizophrenia to the U.S. of more than $155 billion a year.[7] Unfortunately, despite its demonstrated efficacy, CSC is rarely covered by insurance. Congress must take action to ensure that CSC is covered by all public and private payors. Every American experiencing FEP should receive this critical treatment.

Require insurers to report on parity compliance. Under the final regulations implementing the Mental Health Parity and Addiction Equity Act of 2008, insurers are required to conduct comparative analyses to ensure that the treatment limitations that they place on mental health and addiction care are in compliance with the law. The problem is that few regulators ask for insurers' analyses to determine if 1) insurers have done the required analyses and 2) the analyses in fact demonstrate compliance. The Kennedy Forum, American Psychiatric Association, and the Parity Implementation Coalition have broken down the federal rule on non-quantitative treatment limitations[8] into a straightforward six-step process.[9] Because it is based off of the federal non-quantitative treatment limitation rule, this process very closely aligns with a "Self-Compliance

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[3] Walker ER, McGee RE, Druss BG. Mortality in mental disorders and global disease burden implications: a systematic review and meta-analysis. JAMA Psychiatry. 2015;72(4): 334–41.

[4] Nossel, I., Scodes, J., Marino, L. A. et al. Results of a Coordinated Specialty Care Program for Early Psychosis and Predictors of Outcomes. Psychiatric Services Volume 69 Issue 8. 15 May 2018 https://doi.org/10.1176/appi.ps.201700436 https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201700436

[5] Heinssen, R. K., Goldstein, A., Azrin, S. T. Evidence-Based Treatments for First Episode Psychosis: Components of Coordinated Specialty Care. National Institute for Mental Health. April 14, 2014. https://www.nimh.nih.gov/health/topics/schizophrenia/raise/evidence-based-treatments-for-first-episode-psychosis-components-of-coordinated-specialty-care.shtml

[6] NAMI, First Episode Psychosis Programs, A Guide to State Expansions, https://www.nami.org/getattachment/Extranet/Advocacy/FEP-State-Advocacy-Toolkit/FEP-State-Advocacy-Guide.pdf.

[7] Cloutier, et. al, The Economic Burden of Schizophrenia in the United States in 2013. J. Clin. Psychiatry, 2016 June: 77(6): 764-71. Doi: 10.4088/JCP.15m10278.

[8] Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, *Federal Register*, November 13, 2013, https://www.federalregister.gov/d/2013-27086/p-426.

[9] The Kennedy Forum, American Psychiatric Association, Parity Implementation Coalition, "The 'Six-Step' Parity Compliance Guide for Non-Quantitative Treatment Limitation (NQTL) Requirements," September 2017, https://s3.amazonaws.com/pjk-wp-uploads/www.paritytrack.org/uploads/2017/09/six_step_issue_brief.pdf.

Tool" created by the U.S. Department of Labor (USDOL) that plans and regulators can use to help determine compliance.[10] All regulators should require insurers to submit these analyses demonstrating compliance.

Provide additional resources and powers to the U.S. Department of Labor. Currently, USDOL lacks sufficient resources to enforce parity, with only one investigator for approximately every 10,000 plans. Congress must increase USDOL's funding for parity enforcement and conduct vigorous oversight to ensure that USDOL is aggressively enforcing the Federal Parity Act. Congress must also pass the Parity Enforcement Act (H.R. 2848) to give USDOL the power to issue civil monetary penalties for parity violations. Amazingly, USDOL lacks this basic ability to hold plans accountable under current law. The President's Opioid Commission, of which I was a member, called on Congress to give USDOL this power nearly three years ago in its final recommendations.

Implement lessons from *Wit v. United Behavioral Health* (UBH). In March 2019, a U.S. District Court in the Northern District of California ruled that United Behavioral Health, a subsidiary of United HealthCare, the nation's largest health insurer, created flawed medical necessity criteria for mental health and addiction care that inappropriately limited coverage to acute symptom reduction and failed to coverage treatment for patients' underlying chronic conditions. The found that UBH's criteria was inconsistent with generally accepted standards of behavioral healthcare. Unfortunately, such flawed medical necessity criteria are commonplace. States and the federal government should ensure that all medical necessity determinations for mental health and addiction services are fully consistent with generally accepted standards of behavioral healthcare, paying particular attention to the criteria that plans are using to make level of care determinations.

Strengthen crisis response and divert from the criminal justice system. For too long, our country has effectively criminalized mental illness and addiction – at enormous human and economic cost. Ensuring that individuals can receive the care they need is enormously effective at reducing costs associated with crime and the criminal justice system. This is because people with co-occurring substance use disorder and a serious mental illness are over seven times more likely to have been arrested in the past twelve months compared to those without either condition. Yet, one-third of U.S. adults with serious mental illness received no mental health services in the past year, according to the most recent U.S. Behavioral Health Barometer.[11] And, each year, an estimated 356,000 Americans with serious mental illness end up in jail.[12] These terrible numbers both reflect and reinforce systemic racism and the marginalization of individuals who are Black, Indigenous, and People of Color.

Our nation needs to enact systemic reforms that divert people with a mental health or substance use disorder from our criminal justice system and address systemic racism that leads to enormous

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[10] U.S. Department of Labor, *Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA)*, https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/publications/compliance-assistance-guide-appendix-a-mhpaea.pdf.

[11] Behavioral Health Barometer, United States, Volume 5. SAMHSA. https://store.samhsa.gov/system/files/sma19-baro-17-us.pdf

[12] Szabo, L., "Cost of Not Caring: Mental Illness in America," USA Today (July 2014).

disparities. We must create a true crisis response system that effectively responds to people experiencing a mental health emergency. Law enforcement must no longer be our default response. Our crisis response system must be integrated into our new 988 Mental Health Crisis and Suicide Prevention Hotline, and crisis services must be funded by all public and private payors. When individuals do come in contact with the criminal justice system, we must work to divert them into treatment and away from incarceration and criminal records. Besides wasting public resources, individuals who become involved in the criminal justice system experience trauma, worsening of their conditions and making them ineligible for many public services. Furthermore, criminal justice system involvement worsens employment prospects and increases the risk of being re-arrested and becoming homeless. For those already incarcerated, we must ensure they have access to constitutionally protected mental health and addiction treatment services. We must also work to maintain treatment after release by ensuring warm handoffs to mental health and addiction care. The House-passed HEROES Act (H.R. 6800) represents a major step forward in this respect by allowing incarcerated individuals to be enrolled in Medicaid 30 days prior to release.

Invest in permanent supportive housing. Recovery is virtually impossible with stable and safe housing[13], and previous homelessness is a risk factor inhibiting recovery from serious mental illness.[14] Permanent supportive housing, which includes affordable housing and coordinated intensive services under a housing first framework, is therefore essential to promoting recovery. Studies of supportive housing have shown incredible successes, including significantly reduced homelessness, stays in psychiatric facilities, lower involvement with the criminal justice system.[15] All levels of government should work to ensure that every person who lacks stable housing and has a mental health or substance disorder can access permanent supportive housing. Medicaid should cover supporting housing services.

Expand supported employment programs. The vast majority of people with mental health and substance use disorders want to work. For example, for individuals with a serious mental illness, finding employment opportunities is a top priority for more than two-thirds. Employment can significantly aid recovery by improving individuals' self-esteem, increasing social inclusion, and improving overall health. For many people living with mental health disorders, however, finding and maintaining employment can be challenging without supports, with employment rates well below 50% for people receiving public mental health services. Supported employment programs (also called Individual Placement and Support programs) support people in finding appropriate competitive employment opportunities and provide continuing supports during employment. While supported employment programs are have a large evidence base demonstrating their

[13] Mericle AA, Grella CE. Integrating Housing and Recovery Support Services: Introduction to the Special Section. *J Dual Diagn*. 2016;12(2):150-152. doi:10.1080/15504263.2016.1176408

[14] Castellow J, Kloos B, Townley G. Previous Homelessness as a Risk Factor for Recovery from Serious Mental Illnesses. *Community Ment Health J*. 2015;51(6):674-684. doi:10.1007/s10597-014-9805-9

[15] Ehren Dohler, Peggy Bailey, Douglas Rice, and Hannah Katch, "Supportive Housing Helps Vulnerable People Live and Thrive in the Community," *Center on Budget and Policy Priorities*, May 31, 2016, https://www.cbpp.org/research/housing/supportive-housing-helps-vulnerable-people-live-and-thrive-in-the-community.

effectiveness, only about 2% of adults with serious mental illness have access to these programs.[16] Medicaid should cover supported employment services.

[16] Sherman, L.J., Lynch, S.E., Teich, J. and Hudock, W.J. *Availability of supported employment in specialty mental health treatment facilities and facility characteristics: 2014.* The CBHSQ Report: June 15, 2017. Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Rockville, MD.