AMERICAN PSYCHOLOGICAL ASSOCIATION SERVICES, INC.

Written Testimony
of
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Subcommittee on Labor, Health and Human Services, Education, and Related Agencies
"COVID-19 and the Mental Health and Substance Use Crises"

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Chairwoman DeLauro, Ranking Member Cole, and members of the Labor-HHS Subcommittee, thank you for the opportunity to testify today on the vital topic of the COVID-19 pandemic and its impact on the nation's mental health. I am Dr. Arthur C. Evans, Jr., the Chief Executive Officer of the American Psychological Association (APA). APA is the nation's largest scientific and professional nonprofit organization representing the discipline and profession of psychology. APA has more than 122,000 members and affiliates who are clinicians, researchers, educators, consultants, and students. Through the application of psychological science and practice, our association's mission is to make a positive impact on critical societal issues. I also want to thank you and the Subcommittee for your leadership in changing the course of the opioid epidemic and addressing the nation's mental health crisis. Investments in prevention, treatment, and recovery strategies that allow states and communities flexibility to customize their approaches have made a significant difference, one that is more critical today than ever before.

My testimony today will outline steps that members of this Subcommittee can take through the lens of a "population health" approach to combatting this mental health and substance use crisis over both the long and short term, including: (1) Supporting prevention strategies that emphasize early intervention and strengthen communities to address psychosocial factors as part of an overall behavioral health

treatment strategy; (2) Increasing funding for programs to strengthen school-based mental health services, social and emotional learning programs, and trauma-informed practices; (3) Permanently authorizing Medicare to cover audio-only telehealth for mental, behavioral, and substance use disorder services; (4) Investing in critical mental health workforce programs to address mental health workforce shortages, and (5) Expanding research in social and behavioral science at the National Institutes of Health, Centers for Disease Control and Prevention, and the Agency for Healthcare Research and Quality.

Population-Based Approach to Treatment

In my testimony before the House Energy & Commerce Health Subcommittee last June, I stressed the urgency of congressional action to combat a "syndemic" wherein the COVID-19 pandemic is both fueled by and worsening pre-existing socioeconomic inequalities. Longstanding systemic health and social inequities put communities of color at increased risk of contracting COVID-19 or experiencing severe illness, particularly Black, Indigenous, and People of Color (BIPOC), which multiplies the disease burden on these already disadvantaged populations.[i]

Despite progress in the development and distribution of vaccines, the COVID-19 public health emergency continues to reflect a long-overdue reckoning with our tragic history of racism, as well as the continued rise in suicide and the substance abuse epidemic. To change the course of health and racial disparities in our country, we must take a bold step away from the traditional "black box" treatment paradigm, in which we passively wait for people to reach out for help, often only after they are in crisis. This approach is short-signed and insufficient to address the racial inequities in the treatment of mental health and substance use conditions, as well as to meet the growing demand from the pandemic.

A population health approach offers a more proactive way to address the mental health of individuals and communities because it recognizes that our mental health exists on a continuum and

emphasizes that it is critical to meet people wherever they are on that continuum, not passively waiting for them to reach a crisis before we intervene. The pandemic has highlighted the need for this kind of early intervention approach, as there were not enough treatment resources before the pandemic, and with the significant increase in need as people have struggled to cope with this crisis, our mental health and substance use treatment systems will be overwhelmed by the demand.

Rather than allowing minor symptoms of mental or behavioral health disorders to escalate into a crisis, this approach focuses on reducing risk and implementing early intervention strategies informed by psychological science. These strategies go a long way toward addressing the needs of the entire population, including at-risk subgroups, and, in addition to saving lives, save costs by reducing the need for more intensive treatment. To ensure lasting change and build a public health infrastructure that is needed for our nation, we must think outside our traditional treatment model. We have done this for physical health, and it is critical that we do it for mental health.

Overall Mental Health Impact of the COVID-19 Pandemic

The pandemic's impact on the nation's existing mental health needs is well-documented, as data indicate that the public health and economic impact of the pandemic has caused greater levels of stress, anxiety, depression, and trauma. According to APA's January 2021 *Stress in America Survey*, 84% of U.S. adults reported feeling at least one negative emotion—such as anxiety, sadness, and anger—associated with prolonged stress within the previous two weeks. The COVID-19 pandemic was reported among the top sources of stress.[ii] Today, most of our member-clinicians continue to see an increase in patient demand for the treatment of anxiety disorders (74%), depressive disorders (60%), and trauma- and stress-related disorders (51%) than before the pandemic.[iii] Additionally, the drug overdose epidemic has not disappeared with COVID; instead, it has become much, much worse. According to CDC's National

Center for Health Statistics, U.S. past-year drug overdose deaths climbed 24% between July of 2019 and July of 2020.[iv]

The impact of the pandemic on our collective mental health is highly individualized, particularly as COVID-19 affected many communities in diverse ways. Indeed, there is a panoply of reasons why the pandemic can negatively affect an individual's mental health. The economic impact of COVID, for example, is adversely affecting the stress and overall well-being of many adults. Over a third of adults reported difficulty paying for a basic living expense—such as housing, food, or utilities—within the past three months, and more than four in ten adults are reporting a decrease in income or a job loss.[v]

Another reason is the feeling of isolation or loneliness resulting from compliance with public health measures to mitigate the spread of the virus, like physical distancing, remote learning, and "stay-at-home" orders. While it is clear these measures are, and continue to be, vital tools to combat the spread of the virus, research suggests a link between prolonged social isolation and loneliness to poor mental and physical health.[vi] A tracking poll conducted shortly after many states issued COVID-related stay-at-home orders showed that individuals were more likely to report negative mental health effects from the pandemic.[vii]

Prolonged social isolation due to the pandemic has placed inordinate stress on many interpersonal and familial relationships and threatened normal child development, which is dependent on interaction with peers and others. Children remain particularly vulnerable to the mental health impact of the crisis, as the proportion of children's emergency department visits attributable to mental health crises continues to rise throughout the pandemic and significantly outpaces its proportion in 2019.[viii] In a June 2020 survey, nearly a third of parents reported that their child already experienced some degree of harm to their

emotional or mental health.[ix] As with adults, substance use among adolescents remains a concern, as there is some evidence of rising rates of solitary substance use among adolescents.[x]

The mental health impact of this pandemic on frontline health care workers is well-documented, with higher levels of depression, anxiety, and stress noted among many professions.[xi] More than 4 in 10 psychologists reported feelings of burnout, while 3 in 10 reported having been unable to meet the demand for treatment from their patients.[xii] Psychology trainees and early-career psychologists were highly likely to report stress from the financial or career impact of COVID (83%), such as accruing more student loan debt due to limited employment or needing to extend time in graduate school due to disruptions in training, as well as the psychological stress of treating COVID patients (78%) with fewer resources and greater workloads.[xiii]

Addressing Racial and Ethnic Disparities in the COVID-19 Pandemic

The impact of COVID-19 on mental health has been especially prominent among communities of color that are also experiencing disproportionately high rates of COVID-19 cases and deaths.[xiv] In the early months of the pandemic, over 30% of adults surveyed reported at least one adverse mental health condition, including symptoms of anxiety or other stress-related disorder, depressive disorder, or substance use disorder, with significantly higher rates among Black and Latino communities.[xv] Black, Latino, and Asian-American communities are also more likely to report fear of contracting the virus as a source of stress.[xvi] According to data from the Mental Health America Online Screening Program, between January and September 2020, Native American screeners reported the highest increases in rates of depression and suicidal ideation.[xvii]

The pandemic exacerbated preexisting inequities in the social determinants of health that affect these groups, which influence a broad array of health and quality-of-life outcomes and risks. Social and

economic inequality, discrimination, and stigma are at the root of the differences we see among racial and ethnic minorities. When these groups can access care, a variety of factors – including providers' implicit biases and inequitable distribution of health care resources – contribute to lower quality of care and worse outcomes for these groups relative to White patients. These factors, combined with higher risks for chronic health conditions, increase the risk for BIPOC communities.[xviii]

A lack of focus on equitable distribution of testing resources hindered early efforts to achieve a measure of equity in COVID-19 identification and treatment. In the early months of the pandemic, only 27 states reported COVID-19 cases by race, and only 22 states reported COVID-19 deaths by race.[xix] APA's analysis of state testing plans found many of these plans relied on monolithic descriptions of these communities, such as "racial," "ethnic," and/or "minority" rather than specifying an outreach strategy that considers the unique characteristics of the state's BIPOC communities.[xx]

As the national conversation turns away from COVID testing and toward COVID vaccination, many barriers remain to immunizing underserved communities. An effective national distribution dashboard must contain up-to-date evidence on vaccine distribution, efficacy, and safety with attention to race, ethnicity, and socioeconomic status. CDC data suggest BIPOC communities are vaccinated at lower rates, despite the overall uneven impact of COVID on them; however, a comprehensive analysis of these data is hindered by gaps in collecting data on race or ethnicity of those receiving the vaccine.[xxi]

Unfortunately, there remain several obstacles to an effective and equitable vaccine engagement and deployment apparatus in the United States. The Vaccine Administration Management System (VAMS) is supported by the CDC but is underperforming due to a multitude of problems and has been abandoned by most states in favor of alternatives.[xxii] The vaccine distribution system is also hindered by insufficient resources at the outset of this effort, and insufficient federal funding has led to an outsourcing

of distribution. Ultimately, we see this only worsening access issues in communities that are most urgently in need of vaccinations.

Policy Recommendations

Support Population Health Programs that Focus on Early Intervention to Improve Outcomes

We recommend continued investment in interventions that both address social determinants of health and target federal resources to evidence-based disease-prevention strategies. Strengthening the public's knowledge about high-burden health conditions and the value of early intervention are crucial to improving health outcomes. Incentivizing partnerships between Medicaid and public health programs will go a long way to changing the course of health disparities. APA recommends exploring additional flexibilities in program funding to encourage cross-sectoral collaboration to improve outcomes.

Support Permanent Expansions in Medicare Coverage of Certain Audio-Only Telehealth Services

We would also like to note the vital role that telehealth services, including those furnished via audio-only communication, continue to play in this pandemic to both broadly meet the expanded demand for mental and behavioral services and to help remedy long-standing disparities in access to these services. Audio-only services are a critical (and often the only) link to mental and behavioral health services for many individuals and communities that are less likely to have reliable access to technological training or broadband technology—including, but not limited to, older adults, individuals with disabilities, people in rural and frontier areas, lower-income families, and communities of color.

We hope members of this Subcommittee will help us avoid this "access cliff" and permanently authorize Medicare to cover audio-only telehealth for mental, behavioral, and substance use disorder services. Audio-only telehealth coverage under Medicare—which provides health coverage to millions of individuals at high risk for transmitting COVID, such as older adults and people with disabilities—is

currently slated to terminate at the end of the COVID-19 public health emergency. Without a policy change, many of the communities who gained access to mental health services during the pandemic would lose that safety net. Additionally, while APA supports Congress's decision to eliminate certain site-of-service requirements on Medicare tele-mental health coverage in the year-end COVID package, we are concerned that the new six-month in-person service requirement will inequitably limit access to services.

Increase Funding for the Psychology Workforce Programs

Among the most effective ways to expand access to services for those experiencing mental health challenges from the pandemic is to develop the psychology workforce to reach underserved and marginalized communities. Increased investments to support our nation's psychological health and emotional well-being are needed now more than ever, as our nation continues to cope with the impact of the current pandemic. APA would like to express its appreciation for this Subcommittee's support for critical programs that are helping to expand our nation's mental and behavioral health workforce, as well as to improve its racial diversity.

Given the vital role of maintaining a robust mental and behavioral health workforce, and taking into consideration the heightened demand for these services amid the pandemic, we hope that this Subcommittee will include $20.2 million for the Minority Fellowship Program (MFP), $23 million for the Graduate Psychology Education (GPE) Program, and $90 million for the Behavioral Health Workforce Education and Training (BHWET) Grant Program among its appropriations priorities for FY22. The MFP serves a critical function to reduce health disparities and increase the ethnic minority diversity of the behavioral health care workforce. Administered by the Substance Abuse and Mental Health Services Administration (SAMHSA), MFP supports training, mentoring, and career development for psychologists

and other mental health professionals to provide culturally competent mental and behavioral health services to diverse populations.

The GPE Program is the primary federal program specifically dedicated to interprofessional education and training of doctoral-level health service psychologists. Administered by the Health Resources and Services Administration (HRSA), GPE has a dual benefit of supporting the interprofessional training of psychology graduate students and interns, while also expanding access to mental and behavioral health services for high-need populations—such as older adults, children, individuals with chronic illness, veterans, victims of abuse, ethnic minority populations, and victims of natural disasters—in both rural and urban communities. In addition to GPE, the BHWET Grant Program is another essential program administered by HRSA simultaneously working to expand the mental and behavioral health workforce and reduce mental health disparities among underserved populations. Together, GPE and BHWET are supporting a continuum of training that is essential to the development and recruitment of a well-trained mental and behavioral health workforce.

Increase Funding for Programs to Strengthen School-Based Mental Health Programs

Our educational system has been upended with the necessity of implementing online instruction across levels, which is not equally accessible to low-income and other marginalized students.[xxiii] Schools are a key provider of mental and behavioral health services to children.[xxiv] [xxv]. As educators and policymakers work to mitigate adverse impacts on academic achievement, doing so without also addressing the mental and emotional well-being of students will be less effective. We hope the Subcommittee will consider a significant increase in funding for services under the Individuals with Disabilities in Education Act, Project AWARE, and Title IV-A, Student Support and Academic

Enrichment Grants, along with support for school-based health centers that provide an array of services to Medicaid-eligible students and their families.

Expand Research in Social and Behavioral Science to Invest in Health Equity

Psychological science continues to inform innovative solutions to combat challenges related to health equity. For example, to build confidence in COVID-19 vaccines among communities of color,[xxvi] APA developed a guide on "Building Vaccine Confidence Through Community Engagement" to help facilitate transparent and thoughtful conversations between community leaders and individuals to enable informed decisions about vaccine behaviors. To develop more innovative approaches to health equity, we hope the Subcommittee will further invest in National Institutes of Health and National Science Foundation research in social and behavioral science.

We also ask the Subcommittee to increase funding for the health equity offices across HHS to enhance equity-focused emergency preparedness planning and response to public health emergencies, including COVID and future crises. APA recommends that HHS develop and implement a research-based communications strategy aimed at increasing knowledge of COVID-19 transmission risks and prevention among racial and ethnic minorities with co-morbid mental health and substance use disorders. Further, we recommend that HHS ensure culturally and linguistically appropriate care by grantees delivering COVID-related services. Specifically, we hope that the Subcommittee will support a FY 2022 funding level of $49 million for the NIH Office of Behavioral and Social Sciences Research, which supports research examining the social and economic impact of crisis that are likely to have an effect on mental health.

I am grateful to the Subcommittee for this opportunity to testify and look forward to further conversations with you on strategies to address the immediate and long-term mental health impacts of this pandemic to ensure that we are prepared to address the urgent needs of society in an equitable manner.

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