March 20, 2023

U.S. Senate
Committee on Health, Education, Labor, and Pensions
Washington, DC 20510

Dear Chair Sanders and Ranking Member Cassidy, and Members of the Committee:

Mental Health America appreciates the opportunity to provide input for the Committee's March 2, 2023 request to understand drivers of health care workforce shortages. We note that the behavioral workforce was insufficient to meet the nation's needs prior to the pandemic, but now shortages have become dangerously acute and in need of urgent attention. Without available behavioral health professionals, individuals go without support and care for longer stretches of time which leads to the costliest outcomes including hospitalization, incarceration, disability services, and homelessness. We urge significant focus on the behavioral health workforce in the Committee's upcoming legislative proposals.

Mental Health America (MHA) – founded in 1909 – is the nation's leading community-based nonprofit dedicated to addressing the needs of those living with mental illness and to promoting the mental health of all. With over 200 affiliates in 41 states, our work is driven by our commitment to promote mental health as a critical part of overall wellness, including prevention for all, early identification, and intervention for those at risk, integrated care, services, and supports for those who need it, with recovery as the goal.

We urge the Committee to move quickly on legislative proposals to address the growing behavioral health crisis in youth as well as proposals to help older adults and the general population. According to multiple 2022 federal data sets, including the National Survey on Drug Use and Health and the Youth Risk Behavior Survey, suicidality prevalence rates in youth have surpassed the rate in adults. In fact, one in three female adolescents seriously considered suicide in 2021, up nearly 60% from 2011. Trauma including sexual violence is also rising as nearly one in five teenage girls experienced sexual violence in 2021. Additionally, growing evidence shows older adult populations are experiencing more connection issues such as isolation, and loneliness which increase both mental and physical health problems. According to the U.S. Surgeon General, 37% of seniors display depressive symptoms in primary care settings.

Increase and retain the peer support specialist workforce by broadening training of clinicians on inclusion of peer support, including peer support in other workforce programs, and authorizing the Office of Recovery at SAMHSA.

SAMHSA recognizes peer support as an evidence-based practice and defines a peer support specialist as a person who uses his or her lived experience of recovery from mental illness and/or addiction as well as skills learned in formal training to deliver services which promote recovery from mental health conditions and/or substance use disorders. Peer support empowers individuals and groups to self-direct recovery, determine health-related goals, and navigate individual, relational, and community challenges. It is shown to reduce depression and rehospitalization and improve both physical and mental health outcomes.

Although peer support is reimbursable by Medicaid in most states, the Veterans Health Administration, Medicare Advantage plans as a supplemental benefit, and most recently by Medicare in integrated behavioral health settings, many clinicians are uncertain how to incorporate into practice and supervise peer support specialists effectively. This lack of clinician education and training on use of peer support results in underutilization or misuse of the peer workforce in clinical settings and drives many in the field to forfeit work they enjoy for other opportunities. It also hurts individuals who end up waiting weeks or months to see a clinical provider, due to professional workforce capacity issues, especially in rural and remote areas.

Currently, through the Behavioral Health and Education Training (BHWET) grants, the Health Resources and Services Administration provides technical assistance and training to its BHWET grantees to train, certify, hire, and retain peer specialists in clinical settings. This includes limited training of providers and is only given to its grantees - it is not widely available to other health providers that may be interested in offering peer support to their populations served. We urge the committee to expand the BHWET program to offer technical assistance and training to the entire health care workforce on appropriate implementation of peer support in clinical settings and best practices for supervision of peer specialists. This broader technical assistance to those beyond the existing grantee network would extend the reach of medical and behavioral clinicians by increasing the availability of peer support in hospitals, as part of mobile crisis response, and in integrated care settings, and would ensure clinicians work with and supervise peer specialists in a way that honors the principles of peer support.

We also encourage the committee to add peer support specialists to two workforce programs the Minority Fellowship program and the National Health Commission Corps. SAMHSA currently offers a Minority Fellowship Program to diversify the behavioral health workforce. However, this program is currently limited to students seeking masters and higher levels of education and seven professional associations manage the distribution of the fellowships. The program should be expanded to include peer support specialists and should offer intensive professional development and assistance opportunities. The Commissioned Corps of the U.S. Public Health Services does not currently include peer support specialists. This limits its effectiveness in reaching people with mental illness and addictions and in working to comprehensively meet the health care needs of the nation. Peer support specialists would complement the existing corps members and in many settings are working with primary care physicians, therapists, social workers, and others as part of a team-based approach, which has proven to be most effective in treating chronic conditions. They would be an important component of the Commissioned Corps ability to meet the comprehensive health needs of the country at a time when suicide and overdose deaths remain unacceptably high.

In addition, MHA urges the committee to enact language authorizing the Office on Recovery at SAMHSA to advance peer support and recovery services across various clinical and non-clinical settings. This office has been instrumental in ensuring individuals with lived experience, including peer specialists, are centered in discussions with state and federal stakeholders as they implement 988 in the states, develop a national certification for peer specialists, develop core competencies for peer support services, and create supportive environments to expand and retain the peer workforce.

MHA recommends addressing the root causes of workforce shortages by:

- Extending the reach of BHWET training beyond grantees.
- Add peer support specialists to the Minority Fellowship program and the National Health Commission Corps.
- Authorize the Office of Recovery in statute.

Creation of a national warmline network that integrates with the 988 Lifeline.

Warmlines are telephone or text-based services, typically staffed by individuals who have experienced mental health conditions, that provide early intervention services, referrals, and other resources to those who are seeking mental health support but are not experiencing a clinical emergency or crisis. Warmlines are a cost-effective service that helps callers grow resiliency and connection, and also prevent hospitalization and emergency room use.

Mental Health Minnesota, an MHA affiliate, collected survey data of warmline service recipients and found that 25% of all callers would use more intensive, higher cost services, such as the emergency room if they could not reach the warmline. In addition, 96% of callers are calmer at the end of the call, and less than 1% of all warmline calls are transferred of handed off to crisis or emergency services. At a cost of $18 per call, that is significantly less than an emergency room visit, saving an estimated $3.75 million per year.

Warmline legislation should establish a National Peer Support Warmline Program at SAMHSA by creating a network of warmlines under one number and should be integrated with the 988 Lifeline, which provides more urgent support for individuals in crisis. The network would include warmlines serving the general public such as MHA San Francisco's peer warmline and those serving special populations such as Oregon's Youthline and those serving health care workers as would any grantees authorized under the Lorna Breen Health Care Provider Protection Act. This legislation should also collect data on outcomes and impact of access to warmlines as well as best practices for administering a warmline.

MHA recommends addressing the root causes of workforce shortages by:

- Creating a national warmline network program to facilitate increased access to peer services in non-emergencies and collect data on outcomes.

Establish a grant program specifically for community-initiated care.

Community-initiated care is a prevention approach utilized by individuals to support one another and the broader community and is rooted in the principle that the wellbeing of an individual is intrinsically tied to the well-being of others, including the larger community. Community-initiated care focuses on the connections, intentional actions, and efforts to mobilize individuals to support one another and offers a more upstream alternative to psychosocial interventions, even before a crisis or clinical intervention is needed. The Bipartisan Policy Center, in its recent report on Filling the Gaps in the Behavioral Health Workforce, highlights community initiated care and barriers to scaling, including the limited availability of any federal grant funding or financing of community initiated care. In the report, Figure five (5) identifies specific categories to which a new grant program might be assigned through SAMHSA or HRSA.

In community-initiated care, laymen community members are trained to offer supportive assistance to other individuals experiencing distress. Several community-initiated care models have proven successful results including, the Empower Program which was started in India through Harvard Medical School and then established in Texas with private philanthropic funding; The Confess Project of America, in Atlanta, that is training Black barbers to be mental health advocates for their clients in a non-judgmental setting; the Friendship Bench which facilitates peer to peer conversations among students in Canada and is shown to increase help-seeking behaviors in youth; and programs to equip athletic coaches in promoting mental health in students.

MHA urges the Committee to think outside of traditional health workforces and invest in allied health workers, advocates, and most of all community members, who can promote non-clinical psychosocial initiatives to address increasing population needs and alleviate the burden on the existing health care workforce. Federal funding at SAMHSA and HRSA can scale these community programs to build connection and belonging among trusted relationships outside of the health system, and prevent people from needing to engage with the health system.

MHA recommends addressing the root causes of workforce shortages by:

- Creating or increasing grant programs for non-clinical community-initiated care.

Expand Department of Labor jurisdiction to assess civil monetary penalties for parity.

MHA appreciates the focus on grants and other programs to increase the behavioral health workforce. As MHA's recent blog notes, these efforts will not improve affordable access to mental healthcare if providers are not adequately reimbursed for their services and the out of network rates continue to far exceed in network reimbursement. A study of private insurers and Medicare Advantage plans found that behavioral health providers received rates that were less than Medicare rates, while physical healthcare providers received rates that were higher than Medicare rates. Another study found that rate disparities between physical and mental healthcare were increasing over time.

This is a violation of the parity requirements but plans continue to have little incentive to comply with parity in a proactive manner. They can wait for DOL to find a problem and then fix it. With DOL's limited enforcement reach, this is the most effective strategy for plans, but does not help people seeking care. Individuals and families continue to experience long waits or high out of pocket costs for treatment and rates continue to be under what the market requires.
Allowing the Department of Labor to seek penalties for parity violations was a bipartisan recommendation of the Trump Administration's Commission on Combating Drug Addiction and the Opioid Crisis. Giving the Labor Department the power to issue civil monetary penalties was also a key recommendation of President Obama's Parity Task Force. The Genetic Information Non-Discrimination Act (GINA) and the Health Information Privacy and Protection Act both allow civil monetary penalties against entities that violate the law. Bills have previously been introduced to apply the GINA enforcement provisions to the federal parity law. It is important to expand DOL's jurisdiction to cover plans directly.

MHA recommends addressing the root causes of workforce shortages by:

- Allowing the enforcement provisions of GINA to apply to parity laws.
- Expanding DOL's jurisdiction to insurance plans directly, rather than through employers only.

Expand the mental health and addiction crisis workforce by specifying the inclusion of crisis service providers and paraprofessionals in National Health Service Corps programs.
Expanding access to crisis services is a national priority and very timely with the implementation of the 988 system. Without access to a network of crisis services, people experiencing mental health and substance use emergencies end up at increased risk for fatal law enforcement encounters, arrest, or admission to emergency rooms that do not have the capability to provide behavioral health care and thus board for hours or days waiting for transfer to a psychiatric hospital. Workforce is a critical part of crisis expansion and includes a multidisciplinary team of physicians, NPs, PAs, nurses, licensed therapists, and peer support providers. However, the National Health Service Corps programs (NHSC, NHSC-SUD, and NHSC-Rural) make it very difficult for people working in crisis settings to enroll. Crisis services aren't mentioned in the NHSC site requirements at all, leaving it up to individual applicants and sites to interpret the guidelines. Many crisis sites don't fit neatly into the NHSC eligibility guidelines. And because most crisis care is regulated at the state level, there is wide regional variation on how programs are licensed and structured, leaving interpretation up to the regional office to approve or disapprove.

For example, crisis stabilization facilities in Arizona (which is considered by SAMHSA to be a national model for crisis care) have been ineligible as primary mental health sites because they are not "medical homes" where patients receive ongoing outpatient care on a long-term basis. Rather, they are episodic, providing immediate access to outpatient services via walk-in urgent care clinics and continued stabilization via 23-hour observation and subacute brief inpatient stabilization. Many crisis stabilization units are licensed as residential and the NHSC specifically exclude Residential Facilities. Mobile crisis is a critical component of decreasing law enforcement responses to behavioral health emergencies, but Home-Based Health Care Settings are excluded. Without access to the NHSC loan forgiveness and scholarships, crisis programs cannot compete and attract the needed workforce.

Providers of crisis care have had some success getting crisis facilities approved for loan repayment resources via the newer STAR (Substance Use Treatment and Recovery) program, which should serve as a model for future legislative fixes to this problem for all NHSC programs. The STAR program specifically lists crisis stabilization and detox facilities as eligible sites. But it is still unclear whether mobile crisis would be eligible. Eligible disciplines include a wider range of paraprofessionals such as peer supports. Eligibility is determined based on the county opioid overdose rate. However, this metric is only one indicator of the need for crisis services. At this point, most communities in the United States lack basic crisis services, and still rely primarily on police, jails, and emergency rooms to address behavioral health emergencies.

Based on the above, we recommend legislation to:
- Specify crisis programs as eligible NHSC sites and clarify the settings that are included. The included programs should be aligned with the SAMHSA behavioral health

crisis guidelines (contact centers, mobile crisis, crisis urgent care, crisis observation, crisis residential, etc.)

- Expand eligible disciplines for NHSC programs to include paraprofessionals such as peer and family support specialists, which are an integral part of the crisis workforce as outlined in the SAMHSA guidelines and a successful strategy for building a non-law enforcement-based crisis response workforce that better reflects the communities they serve.

We thank the Committee for its attention to the behavioral health shortage, which is a great part of the health care workforce shortage. We hope for a comprehensive response to the growing needs of youth, older adults, and the general population. And, we urge the Committee to build upon mental health programs in the 2018 SUPPORT Act, youth-focused initiatives begun in the Bipartisan Safer Communities Act, parity enforcement at the Department of Labor, and grow investment in community-initiated care, and include peer specialists in workforce programs that do not yet include them. To discuss any of these items, please do not hesitate to reach out to Mental Health America staff.

Sincerely,

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