



March 20, 2023

The Honorable Bernie Sanders
Senate Committee on Health, Education,
Labor & Pensions
136 Hart Senate Office Building
Washington, D.C. 20510

The Honorable Bill Cassidy, M.D.
Senate Committee on Health, Education,
Labor & Pensions
520 Hart Senate Office Building
Washington, D.C. 20510

Re: [Request for Information on root causes of the current health care workforce shortage and potential ways to address it](#)

Dear Chairman Sanders and Ranking Member Cassidy:

On behalf of NAMI, the National Alliance on Mental Illness, we write to thank you for your invitation to provide feedback on the current health care workforce shortage and potential ways to address it. We applaud your continued bipartisan commitment to transforming our nation's system of mental health care and for seeking feedback on this important topic, which is especially troubling in the mental health space. NAMI is the nation's largest grassroots mental health organization, providing education, support, public awareness, and advocacy in communities around the country. We are dedicated to building better lives for people affected by mental illness and have a unique perspective on the mental health workforce shortage and its impact on people with mental health conditions and substance use disorders.

Below, we offer suggestions on the existing mental health workforce shortage and possible legislative solutions. Where possible, we have identified existing legislative language for your consideration. Please note that NAMI recognizes that the workforce shortage also impacts our nation's service members and veterans as well as individuals involved in the criminal justice system. However, we have focused our comments on populations within the jurisdiction of the Senate Health, Education, Labor & Pensions (HELP) Committee.

Overview of Mental Health Workforce Shortage

Each year, millions of Americans with mental illness do not receive any mental health treatment. According to the Substance Abuse and Mental Health Services Administration's (SAMHSA) annual National Survey on Drug Use and Health ([NSDUH](#)), in 2021, among the 57.8 million adults with mental health conditions, 52.8% (31.3 million) did not receive any mental health services. Lack of treatment is particularly acute in marginalized populations. For example, [60%](#) of LGBTQ youth who wanted mental health care in the past year were not able to get it. Additionally, the percentage of adults with a mental health condition in the past year who [received mental health services](#) was lower among Asian (25.4%), Hispanic or Latino (36.1%), or Black or African American adults (39.4%) than among White (52.4%) or Multiracial adults (52.2%). Barriers to accessing mental health care in the U.S. are numerous and multifaceted. In this response, we focus on the significant shortage of mental health and substance use disorder (MH/SUD) providers.

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Access to mental health care is dependent on having appropriately skilled providers available to provide care, yet data consistently shows that there is a shortage of all types of MH/SUD providers across the country. In [55% of U.S. counties](#), there is not a single practicing psychiatrist, and [160 million](#) people live in a designated Mental Health Professional Shortage Area. These national statistics are stark and striking, and underscore what NAMI hears on a daily basis from our 49 NAMI State Organizations and more than 600 NAMI Affiliates across the country. A March 2023 survey of NAMI state chapter leaders about their experience with the mental health workforce revealed that 98.4% believe that there is a mental health workforce shortage in their state and 78.8% believe workforce shortages are the single biggest barrier to people receiving mental health care in their state.

The lack of providers exacerbates unmet needs and leaves more people without options for mental health care. A staggering 50% of NAMI's state leaders hear from people on a daily basis trying to access mental health care but who cannot find a provider, with more than 86% hearing from people who cannot find a provider at least weekly. One NAMI state leader wrote, "For many clients it takes more than 6 months to get through the waitlists that all locations have in this area."

With more than 4 in 10 adults experiencing symptoms of depression and anxiety in recent years, the demand for mental health care has increased significantly, but the workforce gap continues to grow. NAMI encourages the HELP Committee to take the following actions to address the workforce shortage:

Strengthen Mental Health Parity Enforcement to Address Payment Disparities and Inadequate Provider Networks for the MH/SUD Workforce

"There are only two psychiatrists in all of [county in IL] who will take [health insurance]. And we have a population of about 925,000!"

—NAMI leader, March 2023 NAMI workforce survey

"Currently, mental health providers are ranked as some of the lowest paid positions. Many community mental health workers receive minimum wage or only slightly higher. Unlike other medical professions, there is no additional reimbursement for specialty care such as residential, trauma-informed vs. ICU nurses, etc."

—NAMI leader, March 2023 NAMI workforce survey

A critical challenge in the mental health workforce is reimbursement and payment for MH/SUD care – a challenge that directly translates to a lack of access to this type of care for millions of Americans. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ([MHPAEA](#)) sought to correct historical differences in how health insurance covered MH/SUD care when compared to medical/surgical benefits. Under the MHPAEA, provider network adequacy standards, including reimbursement rates, are considered a "nonquantitative treatment limitation" ("NQTL") that must be applied comparably and no more stringently, both in writing and in operation, for MH/SUD benefits as compared to medical and surgical benefits. However, enforcement of mental health parity, and specifically NQTLs, is notoriously difficult.

Enhanced enforcement of MHPAEA could help address inequities in payment for MH/SUD providers. Research has consistently demonstrated that MH/SUD providers are not paid at equal levels to counterparts in the medical field. One [study](#), based on actual claim data in all 50 states for hundreds of health insurance plans, showed that primary care physicians received between 16.3% and 22.3% more than behavioral health care professionals for the same services. Additionally, the study showed that average reimbursements for both mental health and substance use office visits have remained below Medicare allowed amounts over a five year period. In 11 states, reimbursement rates for primary care providers were more than 50% more than for behavioral health providers for the same services. These disparities apply across the mental health workforce. For example, peer support specialists, a critical component to team-based models of care (as discussed below) [earn an average of only \\$15.42](#) – barely above many states’ minimum wage.

We also hear about this from our network of NAMI leaders around the country, with 95.45% of leaders indicating that they don’t think that mental health providers in their state are paid appropriately for the work they do. Inequitable reimbursement contributes to non-competitive salaries for many in the mental health and substance use disorder field and has a chilling effect for people to enter the workforce and to remain in the workforce.

This low level of reimbursement is also a key reason many mental health providers do not take insurance. With enhanced enforcement of MHPAEA, the Committee could also help address inequities in health insurers’ provider networks. Health insurance companies establish provider networks to provide medical care to their enrollees. Provider network adequacy refers to a health plan’s ability to deliver the benefits promised to enrollees by providing reasonable access to a sufficient number of in-network providers in a given specialty area. A network may be inadequate if the network has an insufficient number of providers or facilities to provide care to health plan enrollees, too few providers who are taking new patients, or too few providers who have an available appointment within a reasonable time or distance. Inadequate networks can make it more likely that enrollees obtain care from out-of-network providers, which can be more expensive.

Research consistently shows that MH/SUD provider networks are often less robust than provider networks for other health specialties. National [data](#) consistently shows that over 20% of all people with untreated mental health needs say they did not get treatment because their insurance plans either did not cover mental health treatment at all or offered insufficient coverage. Roughly [one-third](#) of large employers say their networks do not have enough MH/SUD providers to ensure timely access to care. This is even more stark for children’s mental health needs. A behavioral health care office visit for a child is [10.1](#) times more likely to be out of network than a primary care office visit, more than twice the disparity seen for adults.

Thanks to recent congressional action, all applicable health plans are required to have a detailed analysis on-hand to show how they meet NQTL requirements and must be prepared to make this and other parity compliance information available to Departments of Health and Human Services (HHS) and Labor (DOL) upon request. However, a 2022 DOL [report](#) indicated that not a single plan reviewed by regulators satisfied the statutory requirement to complete detailed parity compliance analyses. We believe this indicates that many health plans are still not taking MHPAEA compliance seriously.

The current administration has made mental health parity enforcement a high priority, but the DOL can only do so much using their existing authority and staff bandwidth. While DOL can

investigate and enforce violations of the parity law for private employer plans, it does not have independent authority to assess a civil monetary penalty (CMP) specific to parity.

NAMI urges the Committee to consider the following policies and legislative proposals to leverage MHPAEA as one component of a larger strategy to address the mental health workforce shortage:

- Provide DOL with the authority to levy CMPs against plans that violate MHPAEA, a recommendation made by both Republican and Democratic administrations. These penalties could also be extended to plans that do not produce NQTL analyses that meet the requirements of the statute.
- Establish federal network adequacy standards for employer-sponsored group plans within the committee's jurisdiction, similar to the requirement that all marketplace health plans maintain an adequate network of providers.
- Encourage DOL to assess network adequacy and provider reimbursement rates explicitly when updating MHPAEA regulations.
- [S.4804 \(117th Congress\) Parity Enforcement Act of 2022](#): This legislation, sponsored by Senators Luján, Murphy, and Smith would provide for civil monetary penalties for violations of mental health parity requirements.
- [S.1962 \(117th Congress\) Parity Implementation Assistance Act](#): This bipartisan legislation, sponsored by Senators Murphy, Cassidy, Brown, and Smith, would provide grants to states to implement the federal mental health parity requirements. States receiving the grants must review private health insurance plans' required comparative analysis of nonquantitative treatment limitations (NQTLs) with respect to mental health or substance use disorder benefits.
- [S. 5093 \(117th Congress\) Behavioral Health Network and Directory Improvement Act](#): This legislation, sponsored by Senators Smith and Wyden, would require health plans to do independent audits to ensure their provider networks are up-to-date and accurate, therefore eliminating "ghost networks," seemingly lengthy lists of providers who, in reality, are no longer taking that insurance, not accepting new patients or are otherwise inaccurate.

Incentivize Integration of Care to Leverage Primary Care Workforce and Team-Based Care Models

"I represent the community mental health centers in our state. As a system we have an over 20% vacancy rate."

—NAMI leader, March 2023 NAMI workforce survey

Millions of people in the U.S. have both a physical and a mental health or substance use condition. However, our health care system often separates physical health treatment from MH/SUD care. This creates a fragmented system that leads to poor health outcomes. In fact, people affected by MH/SUD have high rates of other serious health conditions like cardiovascular disease, obesity, and diabetes – contributing to [early mortality](#) for individuals with serious mental illness. Integrating MH/SUD with primary care so that care is provided by an interdisciplinary team of providers, has been shown to improve outcomes and reduce stigma. Integrated health care can create a critical entry point for people to get the care they need,

when they need it. The Committee should implement solutions that promote further integration of care.

Primary care providers often serve as the first line of defense for identifying and managing mental health conditions, due to MH/SUD workforce shortages as well as the convenience and reduced stigma of seeking MH/SUD services in primary care settings. However, primary care providers are often inadequately trained to identify mental health needs, prescribe mental health medications, and provide mental health treatment. In integrated models of care, primary care providers work with mental health providers (e.g., psychiatrists, psychologists, licensed clinical social workers) and care coordinators, who can assist with screening, care management, coordination, patient education to promote self-management of symptoms, and links to social services. This team-based approach can take place all in the same setting or across settings, so long as there is continuous coordination, communication, and patient data sharing. Integrated care provides mental health expertise, support, and resources to primary care providers who are already providing mental health care, as well as broadening access to, and maximizing the use of, the current workforce to address mental health conditions.

Moreover, solutions should consider other ways to leverage existing health care workforce to meet a variety of needs. For example, there is strong [data](#) to suggest that screening for suicide risk in emergency departments would support reductions in suicide attempts.

NAMI urges the Committee to consider the following policies and legislative proposals to improve the integration of MH/SUD services into primary care:

- Authorize grant programs that would incentivize integration and expand integrated care training opportunities for the current and future workforce (e.g., primary care providers, including pediatricians, mental health providers, care managers/coordinators).
- Improve integrated care at primary care settings that disproportionately serve low-income communities and communities of color (e.g., federally qualified health centers).
- [S. 4306 \(117th Congress\) *Improving Access to Behavioral Health Integration Act*](#): This bipartisan legislation, sponsored by Senators Smith and Moran, would establish grants for primary care practices to hire behavioral health providers or otherwise integrate behavioral health and primary care. The legislation would require HHS to develop reporting requirements and metrics to measure the uptake of those models by primary care practices.
- [S. 4472 \(117th Congress\) *Health Care Capacity for Pediatric Mental Health Act of 2022*](#): This bipartisan legislation, sponsored by Senators Casey and Cassidy, would establish programs to provide pediatric mental, emotional, behavioral, and substance use disorder services, particularly in underserved and other high-need areas. The Health Resources and Services Administration (HRSA) would also award funding to children's hospitals and other facilities that provide pediatric services for integrating and coordinating services to meet community needs, workforce training, and expanding sites' capacity to provide services. (Note: we also reference this bill in the section on diversity and cultural competency)
- [S. 467 \(117th Congress\) *Effective Suicide Screening and Assessment in the Emergency Department Act of 2021*](#): This bipartisan legislation, sponsored by Senators Murkowski, King, Kelly, Sinema, Van Hollen, Merkley, and Casey, would require HHS to award grants to hospitals to improve their capacity in identifying patients within emergency departments who are at risk of suicide and connect those patients with mental health treatments and services.

Enhance Options for Loan Repayment Programs

“There just aren’t enough quality therapists to meet the need. Therapists are drastically underpaid, and so it doesn’t draw a lot of candidates.”

–NAMI leader, March 2023 NAMI workforce survey

Many MH/SUD professionals, student debt is a significant concern. According to a recent [report](#) from the Association of American Medical Colleges (AAMC), 73% of medical students graduate with debt as a result of their schooling. Because of low payment rates for mental health providers, the ability for mental health provider specialties to repay loans is even harder. Given that, loan relief programs that encourage professionals to enter the MH/SUD workforce is another way to help address our nation’s behavioral health workforce shortage.

The National Health Service Corps (NHSC) Loan Repayment Program (LRP) is the [largest](#) health-focused student loan repayment program. It provides up to \$50,000 in loan repayment benefits in exchange for an individual providing two years of full-time service in an eligible discipline or specialty at an NHSC-approved service site in a federally designated health professional shortage area. NHSC LRP is available to the following types of MH/SUD providers: psychiatrists, health service psychologists, licensed clinical social workers, psychiatric nurse specialists, marriage and family therapists, licensed professional counselors, and nurse practitioners and physician assistants who focus on mental health or psychiatry. NHSC service sites are primarily outpatient primary-care focused facilities, although Indian Health Service facilities and small rural hospitals are also eligible.

In addition to securing long term stable funding for the NHSC program, we must ensure that the list of NHSC sites is appropriate to encourage a robust MH/SUD workforce. With the recent nationwide availability of the 988 Suicide and Crisis Lifeline, it is critically important that robust crisis services be available. That includes an important [pillar in the crisis continuum of care](#): more crisis centers that can provide support to people who dial 988 and need additional help. Unfortunately, crisis centers are not referenced in the NHSC site requirements. By not being explicitly referenced in NHSC requirements, professionals who serve at crisis centers are often not eligible for the important loan repayment benefits, despite the vital work being done in these centers. By not explicitly being referenced, providers who chose to work in crisis centers are not eligible for NHSC loan repayment.

Additionally, another NHSC regulation has a negative impact on the ability of the workforce to expand access to MH/SUD services. NHSC guidelines mandate that a minimum of 20 hours a week must be spent providing patient care, and only 8 hours can count toward performing “Clinical-Related Administrative, Management or Other Activities,” such as care provided in the community. Certain types of settings, such as Certified Community Behavioral Health Clinics (CCBHCs), have seen significant positive impacts from increasing the amount of patient care that is provided in the communities they serve. However, since these types of activities would not traditionally be included under the “other activities” as listed in the requirement for NHSC eligibility, there is a disincentive for NHSC participants to provide MH/SUD care within the community. Expanding regulations to allow care provided in the community to count toward patient care hours would allow NHSC-eligible individuals to provide care in these invaluable settings.

NAMI urges the Committee to consider the following policies and legislative proposals to expand loan relief programs that will incentivize more professionals to enter the MH/SUD workforce:

- Clarify that crisis centers are NHSC-eligible sites to encourage more professionals to work at crisis response centers.
- Clarify that patient care provided in the community is eligible for hour requirements of the NHSC.
- [S. 862 \(118th Congress\) Restoring America's Health Care Workforce and Readiness Act](#): This bipartisan legislation, sponsored by Senators Durbin and Rubio, would double the funding for the NHSC to provide the program with predictable long term funding.
- [S. 462 \(118th Congress\) Mental Health Professionals Workforce Shortage Loan Repayment Act of 2023](#): This bipartisan legislation, sponsored by Senators Smith, Murkowski, and Hassan, would require HRSA to establish a loan repayment program for mental health professionals who work in designated workforce-shortage areas.
- [S. 3927 \(117th Congress\) Mental Health Excellence in Schools Act](#): This bipartisan legislation, sponsored by Senators Shaheen, Young, Peters and Cramer, would authorize the Department of Education to partner with higher education institutions to help cover students' costs for relevant graduate programs that increase the school-based mental health workforce.

Expand the Role of Peer Support Professionals in the MH/SUD Workforce

"We need to create an 'earn and learn' career ladder from high school, into entry level mental health positions like peer support. This would help relieve some of the workforce shortage and would encourage young people from underserved communities to apply."

–NAMI leader, March 2023 NAMI workforce survey

While there is no national consensus on which provider types make up the “mental health workforce,” estimates often focus on Psychiatrists, Psychiatric Nurse Practitioners (NPs), Psychiatric Physician Assistants (PAs), Psychologists, Social Workers, Marriage and Family Therapists (MFTs), Addiction Counselors, Mental Health Counselors, and School Counselors. However, to augment and expand the MH/SUD workforce, there is a need to include peer support workers in the overall strategy to address the dire MH/SUD workforce shortages. In NAMI’s survey of our state chapter leaders, 90.9% of respondents said there is more work to be done in their state to expand the use of peers in the workforce. NAMI urges the Committee to look at opportunities to expand the use of peer support workers and to encourage team-based care approaches.

Peer support workers (also called peer support specialists) are generally defined as individuals with lived experience of recovery from a mental health condition, substance use disorder, or both, and are trained to support other individuals and their families in recovery.

Complementary to the work of other health care providers, peer support specialists bring their own lived experience to help individuals in achieving their recovery goals. This might include helping individuals engage in their treatment, build and engage support systems, access

important support services (like housing or employment), encourage hope and resilience for recovery, and advocate for an individual's needs. Moreover, peer support specialists help address critical gaps in the mental health workforce by extending the reach and capacity of other health professionals, especially when well incorporated into a team-based structure (peers are a critical component of team-based models of care, as discussed above in the integrated care section).

Peer support is an [evidence-based](#) model of care. Considerable research demonstrates that peer support helps improve patient outcomes, including reducing the need for [inpatient and emergency services](#) and reducing [recurrent psychiatric hospitalizations](#). Peer support specialists are also in position to better understand the needs of an individual and can help improve an individual's sense of [recovery and hopefulness](#), and they can help people improve their [self-efficacy](#). Unfortunately, peer support specialists are not leveraged or recognized for their contributions to the fullest extent.

NAMI urges the Committee to consider the following policies to address the MH/SUD workforce shortage by promoting and expanding the peer support workforce:

- Make the SAMHSA Office of Recovery permanent in authorizing language. The Office of Recovery has a stated goal to expand peer-provided services within every community. In addition to authorizing language, we urge the Committee to direct the Office of Recovery to facilitate the expansion of the peer support workforce.
- Authorize a grant program within HRSA dedicated to training peer support workers, with an emphasis on attracting a diverse workforce. Such a program would allow more individuals to seek the training needed to become peer support workers, and expand the available peer workforce.
- Direct the Bureau of Labor Statistics to develop a Standard Occupational Code (SOC) dedicated to the peer support workforce. The SOC system is a federal statistical standard used by federal agencies to classify workers into occupational categories for the purpose of collecting, calculating, or disseminating data. A code dedicated to peer support workers would allow for better tracking and understanding of the peer workforce.
- Direct HRSA to collect data specific to the peer support workforce.

Address the Diversity and Cultural Competency of the MH/SUD Workforce

"My daughter tried to end her life and the hospital assessed her and said she was fine to go home...I had to demand a referral to outpatient treatment. I was unable to find a BIPOC therapist in my network. An unbelievably frustrating process just to get my daughter the help that I didn't even realize she needed until it was almost too late."

—NAMI leader, March 2023 NAMI workforce survey

The MH/SUD workforce must be sufficient in supply, diversity and cultural competency to meet the needs of people with MH/SUD conditions. Our culture, beliefs, community, sexual identity, values, race and language all affect how we perceive and experience mental health conditions. In fact, cultural differences can influence what treatments, coping mechanisms and supports

work for us. People who perceive more discrimination directed at themselves or other members of their racial or ethnic group are at [greater](#) risk for negative mental health outcomes and are more likely to [underutilize](#) MH/SUD care. About half ([51%](#)) of LGBT adults say they needed mental health services in the past year but did not receive them. And rural residents experience [significant](#) differences in mental health outcomes compared to urban populations, even though the prevalence of mental illness in rural and metropolitan areas is similar. Conversely, when a mental health professional understands the role that cultural differences play in the diagnosis of a condition and incorporates cultural needs and differences into a person's care, it can significantly [improve outcomes](#).

It is essential for culture and identity to be a part of the conversation in MH/SUD care. Unfortunately, the demand for diverse and culturally competent mental health professionals severely outpaces the supply. About [four in ten](#) adults say lack of diversity among mental health care workers is a "big problem", and a survey of NAMI leaders revealed that over 80% of respondents don't think that the demographics of the mental health workforce match the demographics of their state's population. What is critically needed is a behavioral health workforce that is reflective of the communities being served.

NAMI urges the Committee to consider the following policies and legislative proposals to strengthen the diversity and makeup of the MH/SUD workforce:

- Expand existing programs, like the SAMHSA Minority Fellowship Program, which is currently authorized through 2027 at \$25 million each year, to reach more providers and more types of professionals.
- [S. 3479 \(117th Congress\) *Building a Sustainable Workforce for Healthy Communities Act*](#): This bipartisan legislation, sponsored by Senators Casey, Thomas, Smith, Murkowski, and Rosen, would authorize grant funding for community health workers, including mental health workers, to serve in medically underserved communities.
- [S. 4472 \(117th Congress\) *Health Care Capacity for Pediatric Mental Health Act of 2022*](#): This bipartisan legislation, sponsored by Senators Casey and Cassidy would establish programs to provide pediatric mental, emotional, behavioral, and substance use disorder services, particularly in underserved and other high-need areas. HRSA would also award funding to children's hospitals and other facilities that provide pediatric services for integrating and coordinating services to meet community needs, workforce training, and expanding sites' capacity to provide services. (Note: we also reference this bill in the section on integration of care)
- [S. 201 \(117th Congress\) *Improving Access to Health Care in Rural and Underserved Areas Act*](#): This bipartisan legislation, sponsored by Senators Rosen, Murkowski, Sinema, and Wyden, would direct HRSA to award up to 100 grants for federally qualified health centers (FQHCs) or rural health clinics (RHCs) to provide accredited continuing medical education for their primary care providers.
- [S. 4677 \(117th Congress\) *Mental Health Workforce and Language Access Act of 2022*](#): This legislation, sponsored by Heinrich, Padilla, Van Hollen, Klobuchar, Booker, and Warren, would create two demonstration programs within HHS to increase access to mental health services that are provided in languages other than English at FQHCs. HHS must give preference to FQHCs where at least 20% of the patients are best served in a language other than English.

Reducing Burden on Existing Providers

“The providers that are available are burnt out...Everyone is stressed. We are seeing providers just give up.”

–NAMI leader, March 2023 NAMI workforce survey

Individuals in medical and related professions, in general, experience many stressors and are at [high](#) risk for suicide. Physicians have [higher](#) rates of depressive symptoms, burnout and suicide risk than the general population. The suicide rate among male physicians is nearly [1.5 times](#) higher than the general male population, and among female physicians, the relative risk is even more pronounced — more than [double](#) that of the general female population. To maintain access to vital mental health services, it is essential that we support today’s MH/SUD workforce and reduce associated barriers.

Unfortunately, many medical professionals delay or forgo seeking mental health care because of [fear](#) that doing so will jeopardize their ability to practice medicine. This is because many state licensing boards include questions about mental health status in their applications. These questions perpetuate false generalizations about a person’s functionality based on a mental health diagnosis alone, rather than specifically asking about current functional impairments. Moreover, they perpetuate stigma and [discourage many](#) from seeking treatment. Seeking mental health treatment should be normalized and encouraged, without fear of losing one’s medical license.

Another challenge for the existing MH/SUD workforce are administrative barriers, like utilization management. Many health insurance companies rely on utilization management policies like prior authorization, step therapy, or restrictive medical necessity criteria to evaluate the necessity of medical treatments and services and contain costs and service utilization. While these practices often inhibit access to medically necessary care and may harm individuals with mental health conditions, they undeniably increase the administrative hoops that providers must jump through to appropriately treat their patients. The effect on providers is profound: increased administrative burdens relative to other providers can drive mental health providers out of insurance networks, creating greater issues in affordability and unnecessary delays and costs for patients. Said one witness during a [November 2022 Senate Committee on Health, Education, Labor and Pensions \(HELP\) hearing](#) on youth mental health, “[Prior authorization] is mind-numbing. It will take weeks sometimes getting prior authorization for community-based mental health services.”

NAMI urges the Committee to consider the following policies and legislative proposals that support the wellness of MH/SUD providers, reduce barriers to practicing medicine that harm patients with mental illness and limit provider burnout:

- Authorize grant programs to improve mental and behavioral health among health care providers and encourage help-seeking behavior.
- Authorize grant programs for state medical boards that incentivize them to remove unnecessary language in medical licensure and license renewal applications regarding an applicant’s mental health diagnosis or prior mental health history.

- [S. 4412 \(117th Congress\) Protecting Social Workers and Health Professionals from Workplace Violence Act](#): This legislation, sponsored by Senators Sinema and Murkowski, would direct HHS to award grants to states, Indian tribes, and tribal organizations for providing safety measures to social workers, health workers, and human services professionals who perform services in high-risk and potentially dangerous situations.
- [S. 652 \(118th Congress\) Safe Step Act of 2023](#): This bipartisan legislation, sponsored by Senators Murkowski, Hassan, Marshall and Rosen, would amend the Employee Retirement Income Security Act (ERISA) to require group health plans to provide an exception process for any medication step therapy protocol, tools used by health plans to control spending on patient's medications, to help ensure patients are able to safely and efficiently access treatment.

Address Unique Needs of the Children's Mental Health Workforce

"The average wait time for a child recipient of Medicaid to see a therapist in our state is 12 weeks. It might as well be 12 years. When you are in crisis you need help THEN. With no other serious disease would this be acceptable."

—NAMI leader, March 2023 NAMI workforce survey

America's children are in a mental health crisis, as evidenced by the American Academy of Pediatrics, Children's Hospital Association and American Academy of Child and Adolescent Psychiatry (AACAP) officially declared a children's mental health crisis in October 2021. The findings of this declaration were confirmed by the CDC's recent [Youth Risk Behavior Survey](#), which noted that while many areas of adolescent health and well-being are continuing to improve, children's mental health and suicidal thoughts and behaviors have worsened significantly. Each year, one [out of six](#) children will experience a mental health disorder, and [rates of suicide risk](#) among youth, especially teen girls and LGBTQ+ youth, are growing. With timely identification and treatment, we can not only improve outcomes for our children but also save countless lives.

While the causes of our youth mental health crisis are varied and complex, for decades, there has been and continues to be a worsening crisis in the children's mental health workforce. As we all know, children are not small adults, and this is true when it comes to their medical care. Just as children often need the specialty knowledge and training of pediatricians, they often need the specialty knowledge and care of pediatric mental health providers.

The dire lack of pediatric mental health providers is seen across the continuum of care. The National Association of School Psychologists (NASP) recommends a ratio of one school psychologist per 500 students. Sadly, the nationwide ratio is [one school psychologist per 1,211](#) students, with some states approaching a ratio of one school psychologist per 5,000 students. Experts recommend a ratio of one school social worker and one school counselor per every 250 students, but the availability of [these professionals](#) is also lacking – there is a national average of one school counselor per 408 students. There is also a tremendous shortage of Child and Adolescent Psychiatrists. According to AACAP, a sufficient supply of child and adolescent psychiatrists (CAPs) is 47 per 100,000 children. Not a single state has the needed level of 47

CAPs per 100,000 children. Sadly, the national average is an inadequate [14](#) CAPS per 100,000 children.

This workforce shortage means that children who need mental health care are often unable to receive it in a timely manner – or at all. Mental illness is no different from any other disease: the sooner it is diagnosed, and the sooner treatment is started, the better the outcomes. Due to our current dire shortage of pediatric mental health providers, not only are children not receiving treatment in a timely manner, but many mental health programs are performing suboptimally due to a lack of available providers.

NAMI urges the Committee to consider the following policies and legislative proposals to address the pediatric mental health workforce crisis:

- Expand investments in the children's hospital graduate medical education (CHGME) program. Currently, CHGME funding makes up only 2% of total federal spending on graduate medical education (GME), but it supports the training of half of the nation's pediatricians and most pediatric specialists. A robust CHGME program is vital to addressing the pediatric mental health workforce and ensuring that our children are able to access the mental health services they desperately need.
- [S. 3927 \(117th Congress\) *Mental Health Excellence in Schools Act*](#): This bipartisan legislation sponsored, by Senators Shaheen, Young, Peters and Cramer, would authorize the Department of Education to partner with higher education institutions to help cover students' costs for relevant graduate programs that would increase the school-based mental health workforce.
- [S.3848 \(117th Congress\) *Helping Education After Loss Act or the Heal Act*](#): This legislation from Senators Peters and Stabenow would authorize the Department of Education to provide federal funding for schools that have experienced a traumatic event to hire additional school-based mental health providers.
- [S. 1811 \(117th Congress\) *Increasing Access to Mental Health in Schools Act*](#): This legislation from Senators Tester, Cortez Masto and Van Hollen would establish a grant program to increase the number of mental health professionals at low-income schools by supporting partnerships between institutions of higher education and local education agencies that support teaching, training, and employment of school counselors, social workers, and psychologists. Mental health professionals that are unable to participate in a partnership would be eligible for student loan forgiveness after five years of employment at a low-income school.
- [S. 4461 \(117th Congress\) *Expanding Access to Mental Health Training Act*](#): This bipartisan legislation, sponsored by Senators Rosen and Cassidy, would reauthorize grants for training teachers and other school personnel to recognize the symptoms of childhood and adolescent mental health disorders. These grants are awarded by SAMHSA to states, localities, Indian tribes, and nonprofits.

Leverage Digital Tools to Enhance the MH/SUD Workforce

The use of digital health tools, such as telehealth and digital health mobile applications, increased during the COVID-19 pandemic in response to social distancing requirements and the increased MH/SUD needs. Telehealth served as a lifeline for many Americans struggling with isolation, grief, uncertainty about the future, and other stressors during the pandemic.

Telehealth, including audio-only services, can improve access to mental health care and can give patients and providers more flexibility. Telehealth can eliminate transportation barriers and decrease "no-shows" for appointments, resulting in greater continuity of treatment. Additionally,

telehealth can increase access to culturally competent and clinically specific clinicians for underserved individuals. Not surprisingly, telehealth [remains highly utilized](#) for mental health treatment compared to other types of care, which have largely returned to in-person care as the norm.

While digital mental health and wellness apps on mobile devices have the potential to complement and expand access to MH/SUD care, there are remaining challenges in ensuring privacy and that these tools augment the existing workforce rather than take away from it. Between 2019 and 2020, there was a [200% increase](#) in downloads for mental health-focused digital apps with as many as [20,000](#) mental health apps currently on the market. Digital apps also have the potential to empower individuals to self-manage their MH/SUD conditions, as well as the [potential](#) to engage communities of color that have often been less likely to seek care for mental health conditions. However, it is critical that we ensure that these digital mental health apps are effective in improving outcomes.

Concerningly, digital health apps are not subject to data privacy laws, which raises concerns about companies selling and sharing users' data without their consent. The Health Insurance Portability and Accountability Act (HIPAA) only applies to digital apps used in connection with a health care provider, leaving a wide swath of digital health app companies without any accountability for ensuring data privacy protections for individuals. A recent [report](#) from Duke University found that digital mental health apps have sold users' health data, including data on diagnoses, and even identifying information such as names and addresses, to third parties without users' knowledge or consent. Recently, the Federal Trade Commission (FTC) [required](#) one app to settle charges that it had shared sensitive mental health information.

NAMI urges the Committee to consider the following policies and legislative proposals to leverage telehealth as a vehicle to address the MH/SUD workforce shortage while also protecting individuals who choose to use MH/SUD apps:

- Strengthen and expand telehealth coverage for mental health across all settings for employer-sponsored group plans within the committee's jurisdiction.
- Prioritize research to ensure that increased telehealth does not replace or reduce access to more intensive MH/SUD services for people with severe or complex mental health and/or substance use conditions.
- Evaluate barriers to equitable access to telehealth, including in communities of color and rural communities with limited broadband access.
- Evaluate the efficacy of digital mental health apps in improving patient outcomes and define a minimum standard for claims of effectiveness.
- Safeguard privacy by requiring that digital MH/SUD and wellness apps be subject to privacy protections under HIPAA, inform users when their data is no longer protected under HIPAA, allow individuals to select information that can be shared with or sold to third parties, and require the relevant federal agencies to develop best practices for digital apps regarding the use of MH/SUD data.
- [S. 3688 \(117th Congress\) Improving Access to Tele-Behavioral Health Services Act](#): This legislation, sponsored by Senators Warnock, Stabenow and Padilla, would direct SAMHSA to award grants for community-based mental health services, substance-use disorder services, and peer support services, with a particular focus on services provided virtually. Eligible grantees include health departments, law enforcement or first responder agencies, behavioral health programs, nonprofits, and institutions of higher education.

Conclusion

In closing, NAMI would like to commend your leadership and your dedication to addressing the current health care workforce shortage in America. We look forward to the work ahead and stand ready to serve as a resource to you. If you would like to discuss any issues raised in this letter, please contact me at hwesolowski@nami.org.

Sincerely,

A handwritten signature in black ink that reads "Hannah Wesolowski". The signature is fluid and cursive, with the first name and last name clearly distinguishable.

Hannah Wesolowski
Chief Advocacy Officer, NAMI