November 15, 2021

Senators Ron Wyden and Mike Crapo
United States Senate Committee on Finance
Washington, D.C. 20510-6200

Re: Recommendations to address unmet mental health needs

Dear Chairman Wyden and Senator Crapo,

This letter serves as the National Action Alliance for Suicide Prevention (Action Alliance) response to the U.S. Senate Committee on Finance letter (9/21/2021) requesting recommendations to address unmet behavioral health care needs.

The Action Alliance, housed at Education Development Center (EDC), serves as the nation's public-private partnership for suicide prevention. Since 2010, the Action Alliance has brought together senior executives from the public and the private sectors to champion suicide prevention as a national priority and to advance implementation of the *National Strategy for Suicide Prevention (National Strategy)*, which was released by the Action Alliance in 2012. Updated priorities are emphasized in a January 2021 report, *The Surgeon General's Call to Action to Implement the National Strategy for Suicide Prevention (Call to Action).* Previous mental health and behavioral health challenges were exacerbated by the COVID-19 pandemic. In response, the Action Alliance's Mental Health & Suicide Prevention National Response to COVID-19 (National Response) released *An Action Plan for Strengthening Mental Health and Prevention of Suicide in the Aftermath of COVID-19 (National Response Action Plan)* in November 2020 which outlines concrete strategies for achieving meaningful and lasting change in light of COVID-19 and the disparities it brought to the forefront.

The following recommendations to the Committee draw from various Action Alliance reports focused on transforming health systems to reduce suicide developed with partners who are nationally recognized experts in crisis services, parity, and access to behavioral clinical care.

Strengthening Workforce

A strengthened workforce is accessible (by distance and financially), diverse, trained in suicide care, and has access to supports and programs designed to reduce burnout. Research suggests that periodic training of clinical staff (every three years) is a crucial factor in lowering suicide rates among patients. In addition, evidence-based advanced training can assist mental and behavioral health professionals in suicide care competency, as well as cope with work-related stress to reduce burnout. However, the *Call to Action* and the 2014 Action Alliance report, *Suicide Prevention and the Clinical Workforce: Guidelines for Training* (*Guidelines for Training*), note that minimal training opportunities are available in graduate and continuing education settings.

The *Call to Action*, under priority action 4.1, recommends medical/behavioral health graduate programs and professional associations offer training on evidence-based suicide care psychotherapies, and how to

assess suicide risks. A full list of those psychotherapies is listed on page 43 of the *Call to Action*. It also calls for accrediting bodies of medical and behavioral health workforces to require suicide care and risk training for certification. Lastly, the *Guidelines for Training* report offers a template that higher education institutions and professional associations can use to develop a training program for suicide prevention for those in the clinical workforce.

The Action Alliance is collaborating with *The Path Forward for Mental Health and Substance Use* (*The Path Forward*) to increase access to quality evidence-based treatments. This is the only national behavioral health initiative and addresses barriers individuals face in accessing care by calling for improvements to in-network access to behavioral health specialists and expansion of behavioral health integration in primary care (Collaborative Care Model, CoCM). Due to these identified barriers, primary care providers have a role to play in suicide prevention by detecting risk and connecting the person to appropriate services, further supporting the CoCM.

As the nation moves towards implementation of 988 as a three-digit mental health crisis line, it is imperative that attention is given to ensure that the crisis workforce is prepared, sustained, and expanded. Crisis call center staff are the front lines and it is critically important that they are well staffed to handle increased call volume. In addition, the workforce across the crisis continuum needs to be adequately trained and supported with attention given to how to incentivize future workers to enter the crisis services field and attention given to how to sustain the crisis workforce that is in place today.

The Action Alliance recommends the following actions to strengthen the behavioral workforce:

- ***Increase adoption of clinical training in evidence-based suicide care and risk assessment in graduate and continuing education settings*** (as noted in the *Call to Action*, priority action 4.1 and *Guidelines for Training*).
- ***Explore opportunities to incentivize health systems to invest in the clinical training of their workforce to ensure delivery of care by a competent and confident workforce.***
- ***Incentivize the development of a workforce with expertise in the delivery of effective crisis services.*** (as noted in the *National Response Action Plan*, Priority 3.5)

Increasing Integration, Coordination, and Access to Care

Addressing mental health is feasible in primary care by identifying those at elevated risk of suicide, utilization of standardized assessment tools that can be completed by non-mental health professionals, and/or incorporating behavioral health professionals into the primary care setting. The evidence shows brief and limited prevention strategies can be effective in the primary care setting and are consistent with existing health care services. Implementation of such services can be hindered by lack of access to primary care and/or lack of coordination with follow-up outpatient services.

Examples of this issue include a 2017 National Alliance on Mental Illness (NAMI) mental health and substance use care assessment which found that 34 percent of those covered by private insurance (both urban and rural) had difficulty finding a mental health practitioner; clinicians not accepting new clients and/or a lack providers near their work or home was a barrier to care access; and 30 percent of Medicaid recipient respondents reported costs were a deterrent to seeing a therapist. Research by Ahmedani et al. (2014) and Luoma et al. (2002), as cited in the 2018 Action Alliance report, *Recommended Standard Care for People with Suicide Risk: Making Health Care Suicide Safe* (*Recommended Standard Care*), highlighted the need for non-mental health professionals to be skilled in identifying risk. Findings showed of those who died by suicide the majority had visited a primary care

provider in the preceding year, almost half visited a primary care provider in the preceding month, and close to 40 percent had an emergency department visit but no mental health diagnosis.

Compounding this with recently released data 2020 from the Substance Abuse and Mental Health Services Administration (SAMHSA), which suggests that COVID-19 had a negative effect in the nation's wellbeing, these statistics show the urgency for improved coverage and care integration to address barriers to access of care.

Effective methods to integrate mental health and substance misuse treatment into primary care as cited in the *National Response Action Plan* include utilizing models such as Certified Community Behavioral Health Clinics to provide 24-hour crisis care and integrated care and incentivizing wider availability of the Collaborative Care Model (CoCM).

The *Recommended Standard Care* report highlights the importance of follow-up care. In the primary care setting, this can be making an appointment with a mental health professional and following up within 48 hours of the visit. For emergency departments, caring contacts (i.e., phone call, text, email within 48 hours; 2nd contact within 7 days) are important to ensure safety until the person's first outpatient appointment. Caring contacts should also be utilized by outpatient providers for missed appointments or times of care transition.

The *Care Transitions Best Practices* report contains the following recommendations for both inpatient and outpatient behavioral health care systems in order to close gaps in care through collaboration and effective care transitions. Financing improvements are needed to widely implement best practices in care transitions that support these care coordination activities that coordinate care between inpatient and outpatient facilities to reduce suicide and preventing rehospitalizations for suicide risk:

For inpatient psychiatric settings
Support for protocols, and procedures that facilitate safe and rapid referrals to outpatient providers that occur prior to discharge include collaborative protocols, electronic delivery of essential records to the outpatient provider, and scheduling an outpatient appointment to occur within 24-72 hours of discharge. Currently the HEDIS measure that reports how many patients leave inpatient and connect with outpatient provider are poor performing and yet critical to keeping patients safe.

For outpatient providers
Support for protocols and procedures that allow for rapid referrals and prioritize referral acceptance for clients with identified suicide risk history discharged from inpatient care are important. These supports will ensure coordination with the inpatient provider to facilitate the release of important patient information, the ability to discuss client history, course of illness, and clinical approach to help ensure continuum of care. Support for follow-up procedures within those first 24-48 hours to support outreach to those who miss their initial appointment is also critical to ensure patients make it into care.

The Action Alliance recommends the following actions to increase integration, coordination, and access to care:

- ***Improve outcomes for individuals with mental health and substance misuse conditions in primary care by supporting the delivery of effective methods to integrate mental health and substance misuse treatment into primary care.*** (as noted in the *National Response Action Plan*, Priority 2.3)

- ***Finance effective mental health and substance use crisis services in public and private health plans.*** (as noted in the *National Response Action Plan*, Priority 3.4)
- ***Ensure financing mechanisms incentivize the delivery of best practices in care transitions when one is leaving inpatient facility or emergency department and have been identified as at risk for suicide as this gap in financing of suicide care transitions increases the risk of patients not receiving follow-up care.***
- ***Support implementation of the Recommended Standard Care and Care Transitions Best Practices and improved outcome data tracking/analysis to drive system change in suicide care.***

Ensuring Parity

It is imperative health plans cover mental and behavioral health services. Priority 2 of the *National Response Action Plan* calls for federal insurance regulators and Medicaid agencies to enforce Mental Health Parity and Addiction Equity Act (MHPAEA) and ensure that health plans are covering mental health and substance use disorder services in a nondiscriminatory manner, including proper coverage of services necessary to treat chronic mental health and substance use disorders consistent with generally accepted standards of care. Care disparities are barriers which not only impact behavioral health care, but they also impact preventative and early intervention services. In order to achieve the goals of the *National Response Action Plan*, enforcement and implementation of the Mental Health Parity and Addiction Act (MHPAEA) must be addressed.

The Path Forward states a false sense of access to care exists due to inadequate networks. As discussed in the priorities above, this leads many to seek care from a primary care provider which continues to support the implementation of the CoCM. *The Path Forward* reform recommendations (outlined below), if implemented, would have a direct impact on identified disparities and would achieve measureable progress. Issues of parity which existed prior to the COVID-19 pandemic have been exacerbated because of the pandemic. Priority 2, Recommendation 10, of the *National Response Action Plan* states accessibility is impacted by reimbursement and calls for the continuation of waivers which "includes enabling providers to practice across state lines and ensuring full reimbursement at parity with in-person services for outpatient levels of care, such as the Intensive Outpatient/Partial Hospitalization Program and traditional outpatient treatment."

The Action Alliance recommends the following actions to ensure parity:

- ***Ensure compliance enforcement of the MHPAEA***
- ***Support the five evidence-based solutions in The Path Forward, a comprehensive roadmap that provide concrete steps to address each of the 5 solutions:***
    - ***Improve in-network access to behavioral health specialists***
    - ***Expand screening and testing for behavioral health conditions (Measurement Base Care)***
    - ***Expand behavioral health integration in primary care (CoCM)***
    - ***Improve tele-behavioral health***
    - ***Resolve legacy mental health parity issues***

Expanding Telehealth

Priority 2 of the *National Response Action Plan* is to increase access to evidence-based treatment for substance use and mental health disorders in specialty and primary care, which includes calling on federal and state policymakers and commercial payers to make telehealth services permanently accessible and reimbursed as a covered service by continuing the waivers in place as a response to the COVID-19 pandemic. *Pierce and Stevermer (2020)* identified barriers to telehealth include funding

equipment upgrades and telecommunications services for providers to offer telehealth, patient ability to download and use new software, patient income disparities in obtaining mobile devices and computers capable of audio/video telehealth, and inadequate broadband coverage.

The opportunity to sustain the use of telehealth across via phone only and across states lines is a key opportunity to increase access to telehealth and to increase access to mental health care beyond the COVID-19 pandemic. Exploring opportunities to expand and incentivize these efforts are encouraged. According to the FCC's *Connecting Americans to Health Care* report, information and remote patient monitoring/mobile health applications are available to help patients receive care regardless of location and can lead to better outcomes as well as cost savings. Ensuring rural health care providers have access to broadband services at rates comparable to urban areas is also connected to the ability for telehealth to increase access to mental health care.

The Action Alliance calls for:

- ***As stated in the National Response Action Plan:***
    - ***Make telehealth services for mental health and substance use issues permanently accessible and reimbursed as a covered service by continuing the waivers currently in place in response to the pandemic.***
    - ***Ensure access to audio-only telehealth services***
    - ***Enable providers to practice across state lines***
    - ***Ensure full reimbursement at parity with in-person services for outpatient levels of care, such as the Intensive Outpatient/Partial Hospitalization Program and traditional outpatient treatment.***

We thank Chairman Wyden and Senator Crapo for this opportunity to share our expertise and work of behavioral health care access and services. Improvements to the health and behavioral health system can lead to an increase in early intervention and a decrease in suicide deaths. We look forward to working with you to address these critical needs.

With appreciation,

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