



EXCEPTIONAL CARE. WITHOUT EXCEPTION.

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Mental Health Care in America: Addressing Root Causes and Identifying Policy Solutions

Thank you Chairman Wyden, Ranking Member Crapo, and distinguished Members of the Senate Committee on Finance for holding this hearing and providing me with the opportunity to speak today about the state of the mental health care system in America – where it’s working, where it falls short, and how the federal government can play a role in helping to fill the gaps.

My name is Dr. Michelle Durham – I am a pediatric and adult psychiatrist at Boston Medical Center, and Vice Chair of Education in the Department of Psychiatry, where I also trained for my residency, and now have the distinct honor of serving as the Psychiatry residency training Director. I hold a joint appointment at the Boston University School of Medicine as an Assistant Professor of Psychiatry. Boston Medical Center (BMC) is an academic medical center and the largest safety-net hospital in New England. The patients we serve are predominantly low-income, with approximately half of our patients covered by Medicaid or the Children’s Health Insurance Program (CHIP) – the highest percentage of any acute care hospital in Massachusetts.

The BMC Emergency Department, which includes 8 adult psychiatric emergency beds, is among the top ten busiest in the country. Mental illnesses are all too common among the patients BMC treats in our emergency department and across our continuum of mental health care services, which include outpatient integrated mental health care within our pediatric and adult primary care clinics and at local community health center partners, a mental health urgent care clinic, a crisis stabilization unit, and our Boston Emergency Services Team (BEST) provides community-based evaluations and a jail diversion program. At present, BMC does not own or operate a locked inpatient psychiatric unit.

To give you a sense of who BMC serves, 70% of our patients identify as Black or Latinx, approximately one in three (32%) speak a language other than English as their primary

language, and over half live at or below the federal poverty level. The patients we see at BMC who present with mental illness frequently have co-occurring substance use disorders, homelessness, malnutrition, and other health-related social needs linked to poverty. The current COVID-19 pandemic, structural racism, and economic crisis has further exacerbated the mental illness and trauma experienced by our patients. In my ten years at BMC, I have never seen our mental health care services stretched so far beyond their capacity as they are now. Just the other day, we had 25 patients in our psychiatric emergency department – more than triple its capacity – presenting with a much higher level of acuity, some waiting for evaluation and others boarding awaiting placement in an inpatient psychiatric unit.

A severe lack of capacity in our country's mental health care system existed long before the COVID-19 pandemic. The reasons for this are multifactorial, however, for the sake of my remarks today I will broadly categorize them into issues related to the mental health care workforce and patient access to care.

It is widely understood and well-documented that America has a dearth of licensed mental health professionals, in general, and that particular areas of the country – largely rural and outside of the Northeast – are disproportionately impacted.¹ Even where I practice in Boston, which has one of the highest number of child and adolescent psychiatrists per capita in the country, the capacity is insufficient to meet the mental health needs of the community.² Increased Medicare Graduate Medical Education (GME) funding for psychiatry residency slots can help increase the physician workforce. Increased funding for loan forgiveness programs for those who work in underserved areas can help alleviate the \$250,000 of debt that the average medical student has accumulated by the time their residency education is completed. The need to pay off medical school loan burden is also likely to cause physicians to pursue practice in more affluent areas, adversely impacting access to care for lower-income populations.³

Beyond the shortage of providers, the mental health workforce is not diverse – for instance, only 2% of Psychiatrists identify as Black – and not representative or reflective of the U.S. population.^{4,5} In order to address this, we must understand that the issue at its root is a pipeline issue that requires holistic solutions. Just as we say in medicine, that a person's zip

¹ U.S. Health Resources & Services Administration. Health Professional Shortage Areas Data Dashboard. Last Updated: June 10, 2021. data.hrsa.gov/topics/health-workforce/shortage-areas

² American Academy of Child & Adolescent Psychiatry. Practicing Child and Adolescent Psychiatrists Workforce Maps by State. Last Updated: March 2018. aacap.org/AACAP/Advocacy/Federal_and_State_Initiatives/Workforce_Maps/Home.aspx

³ Zimmerschied C. How med student loan burdens can deepen health disparities. American Medical Association. April 27, 2017. ama-assn.org/education/medical-school-diversity/how-med-student-loan-burdens-can-deepen-health-disparities

⁴ Lin L, Stamm K, Christidis P. How diverse is the psychology workforce? American Psychological Association. 2018; 49(2). apa.org/monitor/2018/02/datapoint

⁵ American Hospital Association (2016). The State of the Behavioral Health Workforce: A Literature Review. aha.org/system/files/hpoe/Reports-HPOE/2016/aha_Behavioral_FINAL.pdf

code is more influential than their genetic code in determining life trajectory and long-term health, where a person lives, the color of their skin, and language they speak is highly determinative of the quality of education and resources available, the level of exposure to the mental health field, and stigma associated with mental illness.

In terms of access to mental health services, COVID-19 led to an accelerated adoption of telemedicine. At peak, over 90% of our outpatient psychiatric visits were conducted via telehealth, which enabled BMC to maintain and exceed our pre-pandemic volume of service. That said, while telehealth is an important tool for ensuring patient access to mental health care, it does not work for everyone due to digital inequities that exist related to internet access and digital literacy, especially among low-income communities.

Additional barriers to care exist as a result of disparate insurance coverage, lack of mental health parity, and insufficient insurance uptake by licensed mental health providers (especially for Medicaid). The social determinants of mental health and structural vulnerabilities inherently involved with treating low-income patients require more dedicated time with patients to provide appropriate care. Insufficient Medicaid reimbursement acts as a deterrent for providers to see Medicaid patients, producing a cascade effect in which the more oppressed, marginalized populations have limited to no access to mental health professionals.

I welcome the Senate Finance Committee's involvement in exploring ways for federal policy to improve mental health care across various settings, as well as incentivize and seed the development and scaling up of innovative models of mental health care delivery in order to improve access. A few such examples include:

- Transforming and Expanding Access to Mental Health Care in Urban Pediatrics (TEAM UP) for Children, a pediatric integrated model in federally-qualified health centers in Massachusetts, builds capacity of health centers to deliver high-quality, evidence-informed care to children and families. The model includes behavioral health clinicians and community health workers working with pediatric primary care providers to provide timely mental health treatment.
- The Massachusetts Child Psychiatry Access Program (MCPAP) improves access to treatment for children with behavioral health needs and their families by making child psychiatry services accessible to primary care providers across Massachusetts via remote consultation and education. This model has been expanded to other states such as Connecticut where I completed my fellowship.
- The Wellness and Recovery After Psychosis (WRAP) Program is tailored for people experiencing psychotic symptoms using a team-based approach and providing individual, group and family therapy, medication management, case management, and peer support.

- The Metro Boston Recovery Learning Community (MBRLC) offers peer-to-peer services for people in recovery from mental health and/or substance use issues through peer support, advocacy, and career coaching.

We are at a pivotal time in our country. Over a year into the COVID-19 pandemic, every person's mental well-being has been impacted in some way. The need for a more robust mental health care system has never been more clear or pronounced. Treatment for mental health issues should be accessible – no matter who you are, where you live or your ability to pay. Appropriate investment along the care continuum and for the mental health workforce can improve access to care and retention and recruitment of mental health professionals.

Mental health *is* health and should not be thought of or managed separate or apart from physical health in the ways it historically has been. The time is now to invest in a 21st century mental health care system in America.

Thank you for your time. I look forward to the discussion.