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Mental Health and Substance Use Disorders: Responding to the Growing Crisis

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Thank you Chair Murray, Ranking Member Burr, and distinguished Members of the Senate Committee on Health, Education, Labor, and Pensions (HELP) for holding this hearing and providing me with the opportunity to speak today about mental health and substance use disorders, and the role the federal government can play in responding to a growing crisis impacting millions of Americans across all ages.

My name is Dr. Michelle Durham – I am a pediatric and adult psychiatrist at Boston Medical Center (BMC), board certified in adult psychiatry, child psychiatry, and addiction medicine. I am Vice Chair of Education in the Department of Psychiatry at BMC, where I also trained for my residency. I hold a joint appointment at the Boston University School of Medicine as a Clinical Associate Professor of Psychiatry and Pediatrics.

Boston Medical Center is an academic medical center and the largest safety-net hospital in New England. The patients we serve at BMC 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. 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 frequently have co-occurring mental health (MH) and substance use disorders (SUD) and oftentimes face numerous health-related social needs linked to poverty, including homelessness and malnutrition. The COVID-19 pandemic, structural racism, and economic crisis has further exacerbated the mental illness, substance use, and trauma experienced by our patients.

In my over ten years at BMC, I have never seen our mental health care services stretched so far beyond their capacity as they are now. (It's even worse than when I testified on this subject before the Senate Finance Committee in June 2021.) Since late December, we have had *30-plus patients* in our psychiatric emergency department – more than three to four times its capacity – presenting with a much higher level of acuity, some waiting for evaluation and others boarding awaiting placement in an inpatient psychiatric unit.

In addition to emergency services, BMC provides a continuum of outpatient and inpatient mental health and addiction services, including:

- The Grayken Center for Addiction at BMC, with eleven clinical programs for substance use disorders, is one of the nation's leading centers for addiction treatment, research, prevention, and education;
- Outpatient Mental Health Clinic, which includes the Addiction Psychiatry Treatment Program (APTP) and the Wellness and Recovery After Psychosis (WRAP) Program;
- Outpatient integrated mental health care within our pediatric and adult primary care clinics and at local community health center partners;
- Mental health urgent care clinic;
- Our Boston Emergency Services Team (BEST) provides community-based evaluations, a mental health crisis stabilization unit, and a jail diversion program;
- BMC Health System is in the process of constructing an 82-bed psychiatric facility in nearby Brockton, MA – including 56 inpatient psychiatric beds with the capacity to treat patients with co-occurring substance use disorder and 26 Clinical Stabilization Services (CSS) beds.

BMC has a particular expertise in connecting marginalized communities to health and social services and yet we still find it happens all too often that our **patients with co-occurring mental health and substance use disorders get stuck in a "revolving door,"** falling in and out of the MH/SUD treatment system, in many cases ending up on the streets, either episodically or chronically homeless, only to present repeatedly to our Emergency Department.

One of the issues at play is that the necessary supports for these patients are not in place:

- **Access to affordable, low-barrier housing** – For example, where you don't have to maintain sobriety to get a roof over your head. Not enough of these places exist. Though, BMC is in the very early stages of implementing this "housing first" approach, in partnership with the City of Boston, to get people living on the streets just steps from our hospital campus, oftentimes living with co-occurring MH/SUD, housed first, and then provide wrap-around medical services and social supports.

- **A good aftercare plan** – We think of care transitions as places where patients can fall through the cracks, e.g. leaving detox or an inpatient psychiatric facility to return to the community, but not linking up with outpatient treatment and support. The fact is, more

needs to be done on either end to reach patients, understanding that addiction is a relapsing-remitting disease, and recovery is possible.

- **A supportive community** – When treating co-occurring MH/SUD, the goal is not necessarily to eliminate drug use completely, but how to use substances less so that a person can function in society – i.e. have a job and maintain healthy relationships with family and friends. At the same time, overemphasis on medication at the expense of other forms of treatment and support is likely not the answer. The question is really, how do we get people with co-occurring MH/SUD *everything they need* to survive and be healthy? For so many of our patients, particularly from multicultural/ethnic groups, connection to a supportive community is absolutely essential to recovery. From a care perspective, this can mean integrating community pillars like churches into care plans.

Substance use disorder is in the Diagnostic and Statistical Manual of Mental Disorders (DSM), the mental health field's principal authority for psychiatric diagnoses. It is estimated that about half of people with SUD will develop a MH disorder in their lifetime, and the same is true of people with MH disorders – about 50% will develop a SUD in their lifetime.[1] For the patients we treat at BMC, we estimate that the percentage with co-occurring MH/SUD is likely even higher (55-60%). The idea that mental health and substance use disorders exist in separate siloes is reflected in how our treatment system is designed – but the distinction is artificial, and is not a reflection of how patients experience MH and SUD, or how as a physician I seek to treat MH and SUD.

As a Black, Spanish speaking psychiatrist, waivered to prescribe buprenorphine for opioid use disorder, I'm all too aware of the patients our treatment systems are failing to reach. Preliminary reports from the U.S. Centers for Disease Control and Prevention (CDC) indicate that the last year for which we have data was the deadliest on record, eclipsing 100,000 drug overdose deaths for the first time ever – a grim milestone.[2] While nationally overdose death rates have increased in every major demographic group in recent years, Black men have experienced the largest increases.[3] Even in Massachusetts, where we've seen population-wide drug overdose death rates level off in recent years, the death rates for Black men stand out in

[1] National Institute on Drug Abuse (NIDA). Common Comorbidities with Substance Use Disorders Research Report - Part 1: The Connection Between Substance Use Disorders and Mental Illness. April 13, 2021. https://nida.nih.gov/publications/research-reports/common-comorbidities-substance-use-disorders/part-1-connection-between-substance-use-disorders-mental-illness

[2] U.S. Centers for Disease Control and Prevention, National Center for Health Statistics. Drug Overdose Deaths in the U.S. Top 100,000 Annually. November 17, 2021. https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2021/20211117.htm

[3] Gramlich J. Recent surge in U.S. drug overdose deaths has hit Black men the hardest. Pew Research Center. January 19, 2022. https://www.pewresearch.org/fact-tank/2022/01/19/recent-surge-in-u-s-drug-overdose-deaths-has-hit-black-men-the-hardest/

stark contrast, having increased an astounding 75% between 2019 and 2020 (from 32.6 to 57.1 per 100,000)[4]. Communities of color are suffering disproportionately from COVID-19, and they are dying at disproportionate rates from SUD, bearing the brunt of two compounding public health crises. The COVID-19 pandemic has exacerbated all the inequities those of us practicing in mental health and SUD care have known for decades – workforce shortages, lack of coordinated care, lack of parity, and low reimbursement.

At the same time, Black men have comparably low rates of MH/SUD treatment. Racism and discrimination in all facets of life for these communities have not only made accessing care difficult, but once in treatment, unfair and inequitable systems and practices cause folks to quickly disengage from the treatment they so rightly deserve and need in order to recover. At BMC, we have launched the Health Equity Accelerator to eliminate the race-based health equity gap by utilizing data-driven and community-based research to inform and change the way we approach care for Black people and people of color.[5] We are going directly to people in the community for answers and centering their experience seeking MH/SUD treatment to inform our interventions and programming moving forward.

While we don't yet have the answers we seek, we do know that a one-size-fits-all approach doesn't work and that access is strained across the MH/SUD continuum. That is why reauthorizing funding to support states and localities responding to MH and SUD crises in flexible ways is crucial including through **State Opioid Response Grants, Substance Abuse Prevention and Treatment Block Grants,** and **Community Mental Health Services Block Grants**. Thank you to the Senate HELP Committee for your commitment to coming together on a bipartisan basis to sustain funding in these critical programs over time.

I would like to end with providing a glimpse into the reality of what our patients face every day. In one of my recent shifts in our psychiatric emergency room, a man in his late 20s came in seeking help for his mental health and substance use disorder. In our short time together, he described his onset of opioid use at 9 years of age – his parents were both using substances and there was minimal supervision in the home. As we see often, the patient had experienced years of substance use, time in the carceral system, death of many family members, and unsuccessful relationships with limited to no supports. He has been in and out of treatment over the years as well, but a system that does not allow relapse, a system that does not coordinate care, a system that stigmatizes substance use, a system that criminalizes substance use ultimately

[4] Massachusetts Department of Public Health. Opioid-Related Overdose Deaths, All Intents, MA Residents – Demographic Data Highlights. November 2021. https://www.mass.gov/doc/opioid-related-overdose-deaths-demographics-november-2021/download

[5] Dayal McCluskey P. Boston Medical Center launches new plan to address racial disparities in health care. Boston Globe. November 16, 2021. https://www.bostonglobe.com/2021/11/16/metro/boston-medical-center-launches-new-plan-addressing-racial-disparities-health-care/

exacerbates issues and prevents people from being able to recover and live healthy, fulfilling lives.

Because whether we're talking about mental health or substance use disorders, or co-occurring MH/SUD, I think the question we're seeking to answer is how do we as a society continue to see the humanity in people with mental illness and/or who are using substances, and shape our policies and programs intended to treat and support people with MH/SUD accordingly.

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