Examining Our COVID-19 Response: Using Lessons Learned in
Texas to Address Mental Health and Substance Use Disorders

**presented to the
U.S. Senate Committee on
Health, Education, Labor, and Pensions**

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MEADOWS
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Chair Murray, Ranking Member Burr, and Members of the Senate Health, Education, Labor, and Pensions Committee, thank you for the opportunity to testify today regarding lessons learned over the last year as we responded to long-standing, inequitable, and steadily worsening epidemics of mental illness and substance use made dramatically worse by the COVID-19 pandemic. My name is Andy Keller, and I lead the Meadows Mental Health Policy Institute (Meadows Institute), a Texas-based non-profit policy research institute committed to helping Texas and the nation improve the availability and quality of evidence-driven mental health and substance use care. The Meadows Institute provides independent, nonpartisan, data-driven, and trusted policy and program guidance that creates systemic and equitable changes so all Texans can obtain effective, efficient behavioral health care when and where they need it. We are committed to helping Texas become a national leader in treatment for all people suffering from mental illness and addiction. More information about our work and history can be found on our website.[1]

The COVID-19 Pandemic Has Made a Pre-Existing Epidemic Worse

For over a decade prior to the COVID-19 pandemic, every leading indicator related to mental health and addiction was worsening:

- After increasing by over one-third across two decades, suicide rates paused overall in 2019, but continued to worsen for Black, indigenous, and other people of color.[2] Suicide is now the 4th leading cause of life years lost (after heart disease, lung cancer, and driving) and 2nd leading driver of disability.[3]
- After two years of slight improvement, overdose deaths continued an inexorable rise.[4]
- Poorly treated mental illness is the primary driver of suffering and costs from comorbid conditions, including diabetes, hypertension, infectious disease, and heart disease.[5]
- These factors were exacerbated by inequity for Black, indigenous, and other people of color, who generally receive less culturally responsive care and disproportionately end treatment prematurely, as their access to care is too often frustrated by barriers of language, culture, well-founded mistrust, inaccessibility, and geographic proximity in

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[1] The Meadows Institute website can be viewed here: https://mmhpi.org; our latest policy work here: https://mmhpi.org/work/policy-updates/; and our history here: https://mmhpi.org/about/story-mission/

[2] Stone, D. M., Jones, C. M., & Mack, K. A. (2021). Changes in Suicide Rates—United States, 2018–2019. *MMWR. Morbidity and Mortality Weekly Report*, *70*. https://doi.org/10.15585/mmwr.mm7008a1

[3] The US Burden of Disease Collaborators. (2018). The State of US Health, 1990-2016: Burden of Diseases, Injuries, and Risk Factors Among US States. *JAMA*, *319*(14), 1444. https://doi.org/10.1001/jama.2018.0158

[4] Hedegaard, H., Miniño, A. M., & Warner, M. (2020). *Drug Overdose Deaths in the United States, 1999–2019. National Center for Health Statistics*. https://www.cdc.gov/nchs/products/databriefs/db394.htm

[5] Davenport, S., Gray, T. J., & Melek, S. (2020). *How do individuals with behavioral health conditions contribute to physical and total healthcare spending?* Milliman. https://www.milliman.com/-/media/milliman/pdfs/articles/milliman-high-cost-patient-study-2020.ashx

neighborhoods where the jail or detention center is closer than any clinic or hospital.[6] And the burden of racism adds yet another insidious and toxic stress that increases risks of poor health for a range of health outcomes, including mental illness and addiction.[7]

The pandemic has substantially worsened this pre-existing epidemic:

- Rates of death from overdose jumped in one year by 33%, especially deaths attributable to fentanyl and methamphetamine.[8]
- While rates of death from suicide are still being sorted (and may have dropped slightly),[9] underlying indicators of depression have increased four-fold during the pandemic, affecting one-quarter of Americans,[10] the number of people seriously considering suicide doubled,[11] and emergency department visits for mental health needs by youth have increased by one-third.[12]
- In line with long-standing trends of increased risk for co-morbid illness, people with mental illness were over 65% more likely to contract COVID-19,[13] and mental illness is the second leading driver of COVID-19 based mortality (after age).[14]

And the effects of COVID-19 worsened underlying inequities. Throughout the pandemic, Black (48%) and Latino (46%) adults have been more likely to report symptoms of anxiety and

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[6] Substance Abuse and Mental Health Services Administration. (2020). *Double Jeopardy: COVID-19 and Behavioral Health Disparities for Black and Latino Communities in the U.S. (Submitted by OBHE)* (p. 5). https://www.samhsa.gov/sites/default/files/covid19-behavioral-health-disparities-black-latino-communities.pdf

[7] Paradies, Y., Ben, J., Denson, N., Elias, A., Priest, N., Pieterse, A., Gupta, A., Kelaher, M., & Gee, G. (2015). Racism as a Determinant of Health: A Systematic Review and Meta-Analysis. *PLOS ONE*, *10*(9), e0138511. https://doi.org/10.1371/journal.pone.0138511

[8] Centers for Disease Control. (2020, December 17). *Overdose Deaths Accelerating During COVID-19 [Press Release]*. https://www.cdc.gov/media/releases/2020/p1218-overdose-deaths-covid-19.html

[9] Ahmad, F. B., Cisewski, J. A., Miniño, A., & Anderson, R. N. (2021). Provisional Mortality Data—United States, 2020. *MMWR. Morbidity and Mortality Weekly Report*, *70*. https://doi.org/10.15585/mmwr.mm7014e1

[10] Centers for Disease Control and Prevention. (2021, April 7). *Mental Health—Household Pulse Survey—COVID-19*. https://www.cdc.gov/nchs/covid19/pulse/mental-health.htm

[11] Czeisler, M. É., Lane, R. I., Petrosky, E., Wiley, J. F., Christensen, A., Njai, R., Weaver, M. D., Robbins, R., Facer-Childs, E. R., Barger, L. K., Czeisler, C. A., Howard, M. E., & Rajaratnam, S. M. W. (2020). Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic—United States, June 24–30, 2020. *MMWR. Morbidity and Mortality Weekly Report*, *69*(32), 1049–1057. https://doi.org/10.15585/mmwr.mm6932a1

[12] Leeb, R. T., Bitsko, R. H., Radhakrishnan, L., Martinez, P., Njai, R., & Holland, K. M. (2020). Mental Health–Related Emergency Department Visits Among Children Aged 18 Years During the COVID-19 Pandemic—United States, January 1–October 17, 2020. *MMWR. Morbidity and Mortality Weekly Report*, *69*. https://doi.org/10.15585/mmwr.mm6945a3

[13] Taquet, M., Luciano, S., Geddes, J. R., & Harrison, P. J. (2021). Bidirectional associations between COVID-19 and psychiatric disorder: Retrospective cohort studies of 62 354 COVID-19 cases in the USA. *The Lancet Psychiatry*, *8*(2), 130–140. https://doi.org/10.1016/S2215-0366(20)30462-4

[14] Nemani, K., Li, C., Olfson, M., Blessing, E. M., Razavian, N., Chen, J., Petkova, E., & Goff, D. C. (2021). Association of Psychiatric Disorders With Mortality Among Patients With COVID-19. *JAMA Psychiatry*, *78*(4), 380–386. https://doi.org/10.1001/jamapsychiatry.2020.4442

depression than white adults (41%),[15] and people of color have also disproportionately shouldered the burden of negative financial impacts.[16, 17, 18] Additionally, grief is a primary driver of mental illness,[19, 20, 21] and the pandemic has taken four times as many working age Latino Texans,[22] and nearly 50% more Black children have lost a parent to COVID-19 than other children.[23]

Detection, Early Treatment, and Prevention Turned the COVID-19 Tide

Success against any disease depends on these three factors – detection as early as possible, evidence-driven treatment as early as possible, and prevention – and in under a year, United States researchers and health systems learned to do all three well against COVID-19. We had previously used these approaches to make historic gains for other diseases, including heart disease and cancer. We have yet to do this for mental illness and addiction.

Today in Texas and across the United States more broadly, we do not detect and treat mental illness – to the extent we detect and treat it at all – until eight to ten years after symptoms emerge.[24] Instead, we wait until suffering becomes obvious to the person (or the people around them), too often in the form of a crisis that leads to an emergency room, hospital, or –

[15] Panchal, N., Kamal, R., Cox, C., & Garfield, R. (2021, February 10). The Implications of COVID-19 for Mental Health and Substance Use. *Kaiser Family Foundation*. https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/

[16] Centers for Disease Control and Prevention. (2021). *Health equity considerations and racial and ethnic minority groups*. CDC. https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/race-ethnicity.html

[17] Parker, K., Menasce Horowitz, J., & Brown, A. (2020). *About Half of Lower-Income Americans Report Household Job or Wage Loss Due to COVID-19*. Pew Research Center. https://www.pewresearch.org/social-trends/2020/04/21/about-half-of-lower-income-americans-report-household-job-or-wage-loss-due-to-covid-19/

[18] Fairlie, R. (2020). *COVID-19, Small Business Owners, and Racial Inequality*. National Bureau of Economic Research. https://www.nber.org/reporter/2020number4/covid-19-small-business-owners-and-racial-inequality

[19] Kaplow, J.B., Saunders, J., Angold, A., & Costello, E.J. (2010). Psychiatric symptoms in bereaved versus non-bereaved youth and young adults: A longitudinal, epidemiological study. *Journal of the American Academy of Child and Adolescent Psychiatry, 49,* 1145-1154. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2965565/

[20] Keyes, K. M., Pratt, C., Galea, S., McLaughlin, K. A., Koenen, K. C., & Shear, M. K. (2014). The Burden of Loss: Unexpected Death of a Loved One and Psychiatric Disorders Across the Life Course in a National Study. *American Journal of Psychiatry, 171*(8), 864–871. https://doi.org/10.1176/appi.ajp.2014.13081132

[21] Verdery, A. M., Smith-Greenaway, E., Margolis, R., & Daw, J. (2020). Tracking the reach of COVID-19 kin loss with a bereavement multiplier applied to the United States. *Proceedings of the National Academy of Sciences of the United States of America*, *117*(30), 17695–17701. https://doi.org/10.1073/pnas.2007476117

[22] *COVID's 'untold story': Texas Blacks and Latinos are dying in the prime of their lives*. (2020, December 19). Dallas News. https://www.dallasnews.com/news/2020/12/19/covids-untold-story-texas-blacks-and-latinos-are-dying-in-the-prime-of-their-lives/

[23] Kidman, R., Margolis, R., Smith-Greenaway, E., & Verdery, A. M. (2021). Estimates and Projections of COVID-19 and Parental Death in the US. *JAMA Pediatrics*. https://doi.org/10.1001/jamapediatrics.2021.0161

[24] American Academy of Child & Adolescent Psychiatry. (2012). *Best Principles for Integration of Child Psychiatry into the Pediatric Health Home*. https://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/systems_of_care/best_principles_for_integration_of_child_psychiatry_into_the_pediatric_health_home_2012.pdf

particularly for Black, Indigenous, and other people of color and people in poverty – a criminal justice setting. To focus in on just one major mental illness, depression, less than 1 in 15 of the over 1.5 million Texans suffering from depression each year receive the care needed to achieve symptom remission, and nearly 4,000 die annually from suicide, even though efficacy rates for available depression treatments are over 60%.[25]
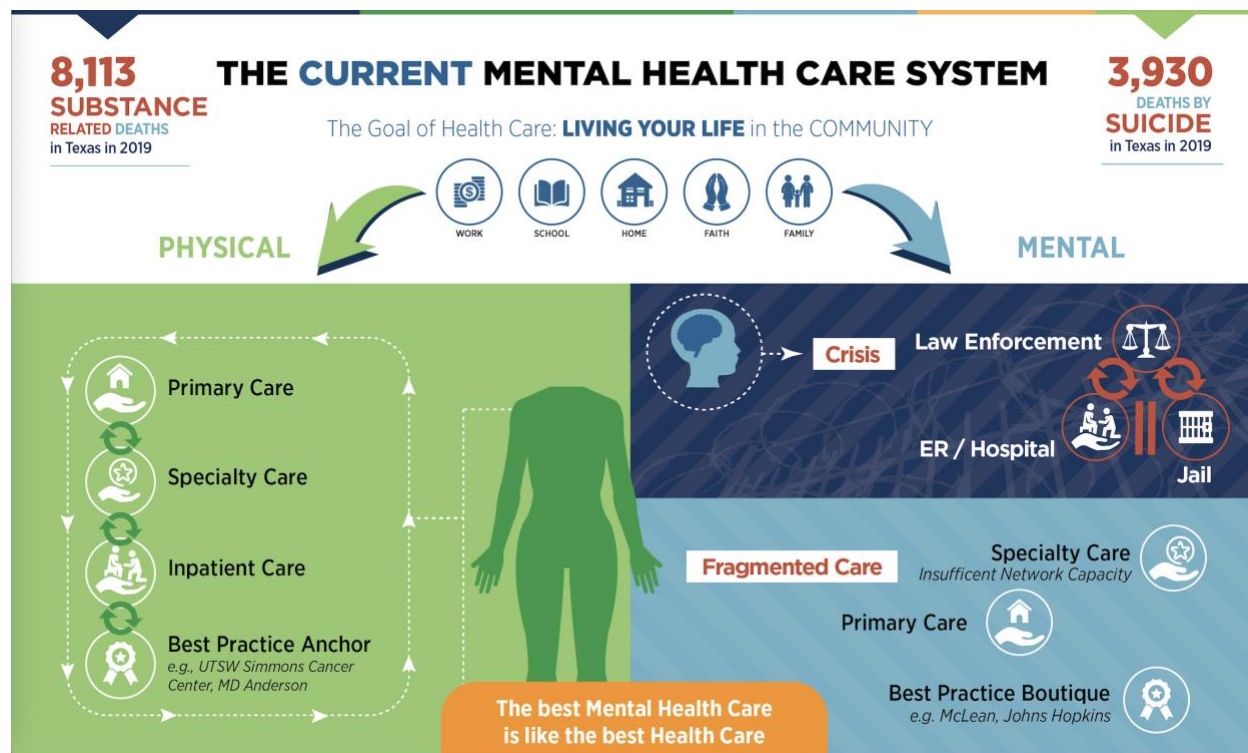
Detection, Treatment, and Prevention Also Work for Mental Illness and Addiction

The primary lesson that needs to be learned from the COVID-19 pandemic is that the nation can rapidly scale up and deliver early detection, treatment, and prevention if we pair the will to act with the necessary resources. Fortunately, this would be much easier to do for mental illness and addiction, because we already know how to successfully detect and treat most of these conditions. At the Meadows Institute, we have modeled that universal access to just two evidence-based treatments – the Collaborative Care Model (CoCM) for depression and Medication-Assisted Treatment (MAT) for addiction – could save almost 40,000 lives a year from suicide (14,500) and overdose (24,000).[26]

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[25] Pence, B. W., O'Donnell, J. K., & Gaynes, B. N. (2012). The Depression Treatment Cascade in Primary Care: A Public Health Perspective. *Current Psychiatry Reports*, *14*(4), 328–335. https://doi.org/10.1007/s11920-012-0274-y

[26] Meadows Mental Health Policy Institute. (2020). COVID-19 Briefing: Modeling the Effects of Collaborative Care and Medication-Assisted Treatment to Prevent COVID-Related Suicide and Overdose Deaths. https://mmhpi.org/wp-content/uploads/2020/09/COVID-MHSUDPrevention.pdf

In addition to COVID-19, American researchers and health care systems have successfully turned the tide on heart disease and cancer using the same approaches. Until the 1980s, we identified heart disease primarily when a person had a heart attack, and we began treatment then, after the heart was damaged, to resuscitate the person and prevent a recurrence. We also used to wait to detect cancer until it resulted in functional impairment – a broken bone, coughing up blood – with devastating consequences and higher mortality rates. Today, we have systems in place in primary care and the community that detect most heart disease and many cancers much earlier, when they are easier to treat successfully, much less likely to be disabling and burdensome to the person receiving care, and less costly to society.

A Unified Vision to Move Forward: Currently Being Scaled in Texas

Early on in the pandemic, the Meadows Institute joined a group of 14 of the nation's leading mental health policy and advocacy organizations to pull together a *Unified Vision for Transforming Mental Health and Substance Use Care* that we released in late 2020. This unprecedented collaboration unified America's two leading provider associations (the American Psychiatric Association and American Psychological Association), leading associations for community-based care (National Council for Behavioral Health) and inpatient care (National Association for Behavioral Health), the nation's largest grassroots advocacy groups (National Alliance for Mental Illness and Mental Health America) and leading policy advocacy groups (The Kennedy Forum, Treatment Advocacy Center, and Wellbeing Trust), and top regional policy leaders like the Meadows Institute (Massachusetts Association for Mental Health, One Mind, Peg's Foundation, and the Steinberg Institute) to design a road map to inform rapid scaling of detection, treatment, and prevention for mental illness and addiction.[27]

Below I briefly summarize how four of the seven pillars of this road map – Early Intervention, Emergency Crisis Response, Equity, and Workforce – are being rapidly scaled today in Texas. I also highlight federal efforts that can catalyze the will and resources needed to accelerate scaling in Texas and nationally to turn the tide on mental illness and addiction, just as we have for COVID-19 in the last year, and heart disease and cancer over the prior two decades.

Early Intervention and Prevention

For Children and Youth. Mental illnesses are primarily pediatric illnesses, with half of all cases manifesting by age 14 and three-quarters by the time the brain stops developing in our mid-

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[27] American Psychiatric Association, American Psychological Association, The Kennedy Forum, Massachusetts Association for Mental Health, Meadows Mental Health Policy Institute, Mental Health America, National Alliance on Mental Illness, National Association for Behavioral Healthcare, National Council for Behavioral Health, One Mind, Pegs Foundation, Steinberg Institute, Treatment Advocacy Center, & Well Being Trust. (2020). *A Unified Vision for Transforming Mental Health and Substance Use Care*. https://mmhpi.org/wp-content/uploads/2020/12/UnifiedVision2020.pdf

twenties.[28, 29] The key therefore is to deploy screening, detection, and early intervention in the two places where America is best able to help children – the family doctor and the local school.

We are scaling these solutions today in Texas. In mid-2019, the Texas Legislature overwhelmingly approved and Governor Abbott signed into law Senate Bill 11, which brought together the state's 12 publicly-funded medical schools to form the Texas Child Mental Health Care Consortium (TCMHCC). It was funded with an initial $100 million to provide universal access to child psychiatry consultation in primary care through a Child Psychiatry Access Network (CPAN), urgent access to psychiatric telehealth care and referrals in Texas schools through the Texas Child Health Access Through Telemedicine (TCHATT) program, and broad expansion of workforce training and the public psychiatry workforce more broadly.[30]

The Executive Committee of TCMHCC developed its implementation plan pre-pandemic[31] and launched on time despite the pandemic in May 2020. Since then, the TCMHCC has:
- Engaged nearly 5,000 pediatric primary care providers in the CPAN program, and
- Expanded TCHATT access to over 1.35 million Texas students (soon to reach 2 million), with thousands served, including 12.5% Black and 34% Latino students – numbers proportionate to the broader child population of Texas.

We are also working closely with the Texas Education Agency (TEA) to create guidance and supports for local school districts to implement systemic supports to ensure that local education agencies can provide a Multi-Tiered System of Supports, leveraging within an Interconnected School Framework.[32] The JED Foundation has also released updated guidance for these system-level supports.[33]

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[28] Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593–602. https://doi.org/10.1001/archpsyc.62.6.593

[29] Kim-Cohen, J., Caspi, A., Moffitt, T. E., Harrington, H., Milne, B. J., & Poulton, R. (2003). Prior juvenile diagnoses in adults with mental disorder: Developmental follow-back of a prospective-longitudinal cohort. *Archives of General Psychiatry*, *60*(7), 709–717. https://doi.org/10.1001/archpsyc.60.7.709

[30] You can read more about all of these programs at https://tcmhcc.utsystem.edu.

[31] See https://www.utsystem.edu/pophealth/tcmhcc/assets/files/resources/TCMHCC-Report%20to-the-LBB.pdf.

[32] For more information, see: https://mmhpi.org/wp-content/uploads/2019/10/RoadmapAndToolkitForSchools.pdf

[33] For more information, see: https://www.jedfoundation.org/wp-content/uploads/2021/02/The-Comprehensive-Approach-to-Mental-Health-Promotion-and-Suicide-Prevention-for-High-Schools_JED.pdf

Schools Engaged in the Texas Child Health Access Through Telehealth (TCHATT) Program
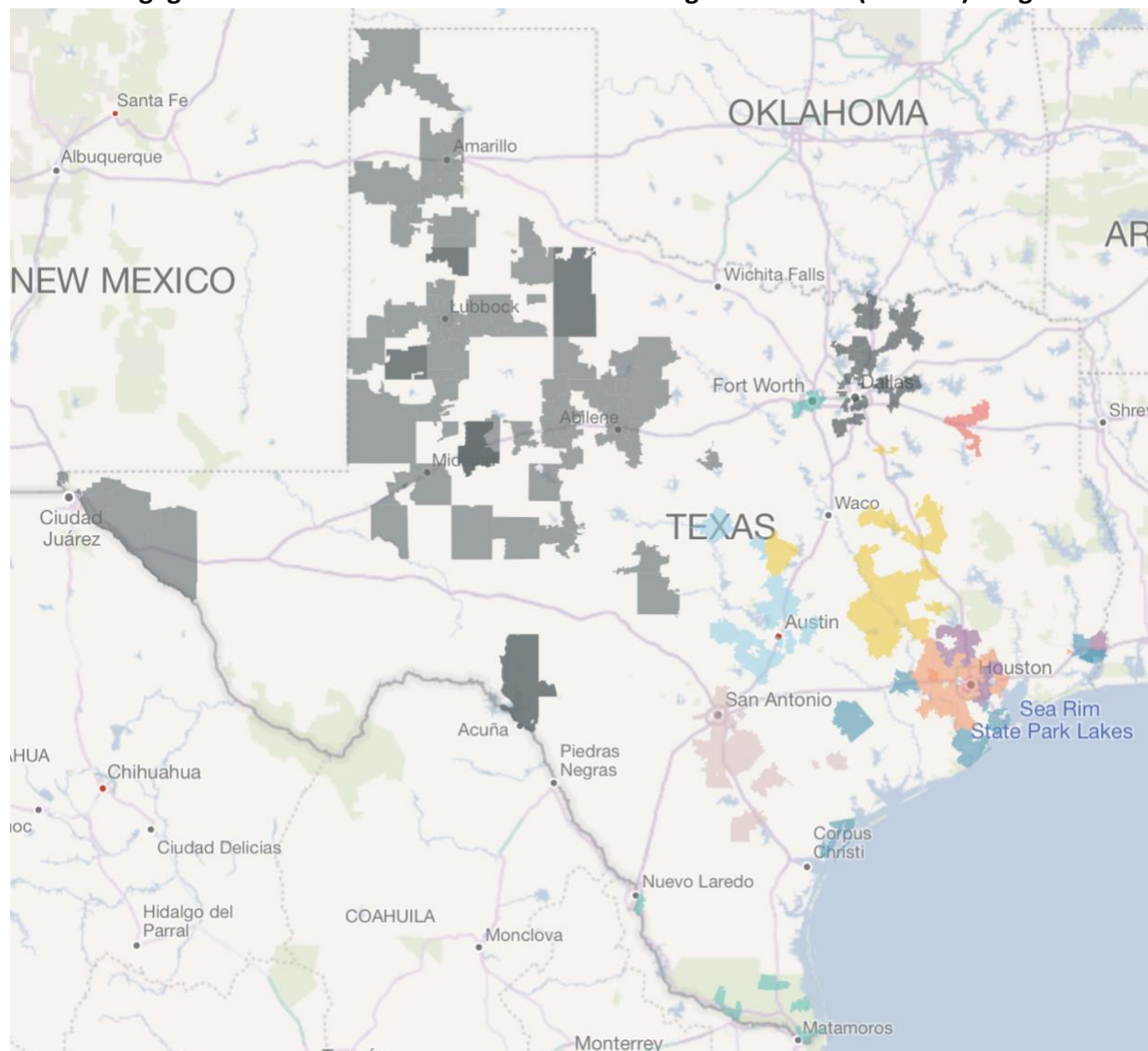
Previous COVID-19 relief bills and the American Rescue Plan expanded funding for psychiatry access programs like CPAN and school-based mental health supports, but the scope of the psychiatry access expansion nationally is less than what we have funded in Texas alone and the school-based efforts lack guidance on infrastructure development initiatives such as TCHATT.

Recommendations

Congress should scale funding for psychiatry access programs commensurate with the national need, in partnership with states, and should encourage use of telehealth in school-based mental health and substance use disorder services expansion. Systemic supports such as those we are helping TEA implement in Texas and those promoted nationally by the JED Foundation should also be incorporated into school-based efforts.

Congress should also make regulatory relief on telehealth permanent, just as states such as Texas are poised to do with overwhelming bipartisan support.[34]

Suicide and Depression. We are also scaling measurement-based care (MBC) and the Collaborative Care Model (CoCM) in primary care practices across Texas, beginning in North Texas. In 2018 we developed The Cloudbreak Initiative[35] in partnership with the UT Southwestern O'Donnell Brain Institute's Center for Depression Research and Clinical Care. The Cloudbreak Initiative is scaling detection and treatment in primary care across the region's health systems using two proven approaches: **Measurement-Based Care (MBC)**, the systematic use of repeated, validated measures to track symptoms and functional outcomes in clinical settings,[36] and the **Collaborative Care Model (CoCM)**, an approach to the treatment of depression pioneered by the AIMS Center at the University of Washington and refined over the last three decades that involves the integration of care managers and consultant psychiatrists directly within primary care settings to provide care that can help over 40% of people treated in primary care achieve full remission and another 25% achieve substantial relief. CoCM is well-established with over 80 randomized control trials documenting its efficacy, and its ability to improve health outcomes overall has been proven to bend the cost curve with a six-to-one cost savings primarily derived by improvements in co-morbid diseases that depression worsens, like diabetes and hypertension.[37] Improved outcomes for opioid-use disorders have also been demonstrated.[38] Cloudbreak is underway now, supporting in North Texas through scaling grants and technical assistance with the Methodist Health System and Baylor Scott & White Health. We are on track to help the region's 12 major health systems commit to achieving universal depression care within the next four years. Just as importantly, Cloudbreak is based on an

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[34] For more information on Texas House Bill 4 (Price – Amarillo), please see: https://www.statesman.com/story/news/politics/state/2021/04/14/texas-house-tentatively-approves-telehealth-drug-savings-bills/7221081002/

[35] Read more about Cloudbreak here: https://mmhpi.org/the-cloudbreak-initiative/

[36] On its own, MBC has been shown to improve patient outcomes by 40 to 60%. See Alter, C. L., Mathias, A., Zahniser, J., Shah, S., Schoenbaum, M., Harbin, H. T., McLaughlin, R., & Sieger-Walls, J. (2021). *Measurement-Based Care in the Treatment of Mental Health and Substance Use Disorders*. Dallas, TX: Meadows Mental Health Policy Institute. https://mmhpi.org/wp-content/uploads/2021/03/MBC_Report_Final.pdf

[37] Carlo, A. D., Barnett, B. S., & Unützer, J. (2021). Harnessing Collaborative Care to Meet Mental Health Demands in the Era of COVID-19. *JAMA Psychiatry*, *78*(4), 355. https://doi.org/10.1001/jamapsychiatry.2020.3216

[38] Olfson, M., Zhang, V., Schoenbaum, M., & King, M. (2020). Buprenorphine Treatment by Primary Care Providers, Psychiatrists, Addiction Specialists, And Others. *Health Affairs*, *39*(6), 984-992. https://doi.org/10.1377/hlthaff.2019.01622

LaBelle, C. T., Han, S. C., Bergeron, A., & Samet, J. H. (2016). Office-Based Opioid Treatment with Buprenorphine (OBOT-B): Statewide Implementation of the Massachusetts Collaborative Care Model in Community Health Centers. *Journal of Substance Abuse Treatment*, *60*, 6–13. https://doi.org/10.1016/j.jsat.2015.06.010

approach (CoCM) proven to work just as well for Black, Latino, and other communities of color.[39]

CoCM is also the only evidence-based medical procedure currently reimbursable in primary care, including by Medicare, nearly all commercial payers,[40] and an increasing number of Medicaid programs (including hopefully Texas by next month). Leading employer and private sector purchasing groups are also calling for its expansion.[41] The potential cost-savings of wide-spread implementation are considerable: a pivotal 2013 study found Medicare and Medicaid savings of up to six-to-one in total medical costs and estimated $15 billion in Medicaid savings if only 20% of beneficiaries with depression received it.[42] The primary barrier to adoption are start-up costs and technical assistance provided in North Texas by Cloudbreak.

Recommendations

Scale the Collaborative Care Model. Congress can create similar momentum nationwide by providing grants to primary care practices and health systems, as well as technical assistance to enable them to implement CoCM effectively. While the 2016 CURES Act provided grants to community health centers, health systems and primary care practices more broadly need support to accelerate CoCM implementation, similar to action taken early in the last decade to speed adoption of electronic health records. Nationwide, primary care practices operate on thin financial margins with limited support staff, making implementing a new delivery model difficult. Establishing an integrated care program also requires up front expenses, such as hiring staff and purchasing or upgrading software and electronic health records. This can be a barrier to all practices, but especially those smaller, rural, and independent practices. In addition, in order to ensure that practices are successful with integration, technical assistance is also needed to help ensure fidelity to required staffing models, workflows, new technology, and

[39] Wells, K., Sherbourne, C., Schoenbaum, M., Ettner, S., Duan, N., Miranda, J., Unützer, J., & Rubenstein, L. (2004, April). Five-year impact of quality improvement for depression: Results of a group-level randomized controlled trial. *Archives of General Psychiatry, 61*(4), 378–386. https://pubmed.ncbi.nlm.nih.gov/15066896/

Areán, P. A., Ayalon, L., Hunkeler, E., Lin, E. H. B., Tang, L., Harpole, L., Williams, J. W., Unützer, J., & IMPACT Investigators. (2005, April). Improving depression care for older, minority patients in primary care. *Medical Care, 43*(4), 381–390. https://pubmed.ncbi.nlm.nih.gov/15778641/

Ell, K., Aranda, M. P., Xie, B., Lee, P-J., & Chou, C-P. (2010, June). Collaborative depression treatment in older and younger adults with physical illness: Pooled comparative analysis of three randomized clinical trials. *American Journal of Geriatric Psychiatry, 18*(6), 520–530. https://pubmed.ncbi.nlm.nih.gov/20220588/

[40] Alter, C., Carlo, A., Henry Harbin, & Schoenbaum, M. (2019). Wider Implementation of Collaborative Care Is Inevitable. *Psychiatrics News*. https://doi.org/10.1176/appi.pn.2019.6b7

[41] For more information, please see: https://www.nationalalliancehealth.org/www/initiatives/initiatives-national/workplace-mental-health/pathforward

[42] Unützer, J., Harbin, H., Schoenbaum, M., & Druss, B. (2013, May). *The collaborative care model: An approach for integrating physical and mental health care in Medicaid health homes*. Health Home Information Resource Center. http://www.chcs.org/media/HH_IRC_Collaborative_Care_Model__052113_2.pdf

record keeping. In early 2021, scaling strategies similar to the above for CoCM were endorsed in comprehensive studies by both RAND[43] and the Bipartisan Policy Center.[44] These strategies are also fully aligned with the evidence-based services recommendations (Priority 2) of the Mental Health and Suicide Prevention National Response to COVID-19.[45]

Congressional action should also be taken to eliminate co-pays for CoCM in Medicare, Medicaid, and commercial coverage. Reducing barriers to collaborative care is critical to ensure patient engagement. Clinicians report patients choosing not to enroll or continue in the program because of the co-insurance requirements, despite understanding the benefits of the program and the potential for long term cost savings that occur when addressing mental health or substance use with CoCM. The negative impact of co-pays is particularly problematic for patients with high-deductible plans, and disincentives to address mental health and substance use disorders like these are a primary driver of comorbid physical conditions cited earlier.

Making telehealth waivers permanent, as discussed above, and full enforcement of the Mental Health Parity and Addiction Equity Act are equally important levers to increasing access to and reimbursement of needed mental health and addiction services.

It is also necessary for federal agencies to coordinate efforts across agencies, aligning policies and braiding funding. In addition to providing scaling grants, the Centers for Medicare and Medicaid Services (CMS) should align payment policies through Medicare and Medicaid, and the Substance Abuse and Mental Health Services Administration should align block grant and targeted grant funding to promote system development. The National Institutes for Mental Health can continue to push the envelope on service improvement with the more real-world focus that current leadership has provided, and the Department of Labor can align parity enforcement efforts in support. For the school-based efforts noted above, the Department of Education must also be on board, and for the 911 reforms noted below, so must the Department of Justice.

Scale Early Intervention for Psychosis with Coordinated Specialty Care. Coordinated Specialty Care (CSC) is the benchmark treatment for adults suffering from schizophrenia and other

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[43] McBain, R. K., Eberhart, N. K., Breslau, J., Frank, L., Burnam, M. A., Kareddy, V., & Simmons, M. M. (2021). *How to Transform the U.S. Mental Health System: Evidence-Based Recommendations*. RAND Corporation. https://www.rand.org/pubs/research_reports/RRA889-1.html

[44] BPC Behavioral Health Integration Task Force. (2021). *Tackling America's Mental Health and Addiction Crisis Through Primary Care Integration: Task Force Recommendations*. Bipartisan Policy Center. https://bipartisanpolicy.org/wp-content/uploads/2021/03/BPC_Behavioral-Health-Integration-report_R01.pdf

[45] Read more about that here: https://nationalmentalhealthresponse.org/priority-2-calls-action

psychotic disorders.[46] Texas has been able to use federal Mental Health Block Grant (MHBG) funding thanks to the required CSC set-aside to implement 29 teams to date,[47] but we estimate that eight times as many teams are needed to meet the need statewide.[48] America's response to the pandemic has shown us that we can fully scale treatment if we have the will and resources to do so, and Congress could readily provide care to the 100,000 Americans in need each year by:

- Dramatically expanding the CSC set aside in the MHBG to fund program start-ups, and
- Requiring Medicare, Medicaid, and commercial payers to cover CSC care.[49]

Address Social Determinants of Health for People with Severe Mental Illness and Addiction. The American Rescue Plan includes substantial funding for housing, but decisions on how to invest these funds are left to local communities. We estimate that one in five homeless Texans in our major cities experience chronic homelessness, most due to complex mental health, substance use, and other debilitating health conditions. As additional infrastructure bills are considered by Congress, prioritizing use of federal housing funds for people with severe mental illness and addiction and fully funding permanent supported housing supports for the roughly 15% of people homeless in Texas who need dedicated, ongoing supports is needed.

People with severe mental illness and addiction also need to be prioritized for COVID-19 vaccines, given their higher rates of both infection and death previously cited. Last week, my Unified Vision colleagues Lisa Dailey, of the Treatment Advocacy Center, and Paul Gionfriddo, of Mental Health America, published an op-ed in The Hill[50] showing the way forward by:

- Allocating vaccines to inpatient psychiatric hospitals, community mental health centers, community behavioral health organizations and other mental health and substance use service providers best positioned to reach these groups,
- Creating multimedia materials for states and local communities to provide education about the importance of vaccination and dispelling myths about vaccine safety tailored to people suffering severe mental illness and addiction,

[46] Kane, J. M. et al. (2016). Comprehensive Versus Usual Community Care for First-Episode Psychosis: 2-Year Outcomes from the NIMH RAISE Early Treatment Program. *The American Journal of Psychiatry, 173*(4), 362–372. https://doi.org/10.1176/appi.ajp.2015.15050632

[47] Intellectual and Developmental Disability and Behavioral Health Services Department. (2020). *Intellectual and Developmental Disability and Behavioral Health Services: Fiscal Year 2020 In Review*. Texas Health and Human Services Commission. https://mmhpi.org/wp-content/uploads/2021/04/IDD-BHS-Annual-Report-FY2020-003.pdf

[48] Meadows Mental Health Policy Institute. (2020). *Coordinated Specialty Care for Texans*. https://mmhpi.org/wp-content/uploads/2020/09/CoordinatedSpecialtyCare.pdf

[49] Jackson, B., Sternbach, K., Dixon, L., Harbin, H., Schoenbaum, M., & Rowan, M. (2020). *Payment Strategies for Coordinated Specialty Care (CSC)*. Meadows Mental Health Policy Institute. https://mmhpi.org/wp-content/uploads/2020/10/CoordinatedSpecialtyCare-PaymentStrategies.pdf

[50] Daily L. & Gionfriddo, P. (2021, April 21). We need a national vaccination strategy for people with severe mental illness. *The Hill*. https://thehill.com/opinion/healthcare/549484-its-time-for-a-national-vaccination-strategy-for-people-with-severe-mental

- Including peer support specialists deployed to community health centers and public health agencies to address emotional or mental health stressors related to vaccination for individuals with severe mental illness, and
- Gathering and publishing data on the vaccination rates on these groups to determine whether subgroups of people who experience multiple disparities can access vaccines.

Reform Emergency and Crisis Response

We have also witnessed during the pandemic the tragic consequences that result from our overreliance on public-safety response to mental health emergencies that require police agencies to carry the burden for the entire community[51] and the lack of inpatient treatment resources in virtually every community in the country,[52] systemic gaps that fall disproportionately on Black, indigenous, and other people of color.[53]

While national efforts to address crisis care through the 988 system and non-police response are making gains, there is still a need to reform the 911 emergency response system more broadly. Major communities across Texas are now doing just that, and earlier this year Austin was one of the first communities nationally to add a mental health response option to its 911 call center. This transformation focuses on the implementation of a health-driven response to mental health emergency calls through the 911 system and is based on a variation of the Multi-Disciplinary Response Team (MDRT) approach. The longest-standing MDRT program being implemented in Texas is the Dallas Rapid Integrated Group Healthcare Team (RIGHT Care),[54] and MDRT variations similar to RIGHT Care are being implemented with Meadows Institute support in large (Austin, El Paso, San Antonio) and smaller (Abilene, Galveston) Texas communities.

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[51] Treatment Advocacy Center. (2019). *Road Runners: The Role and Impact of Law Enforcement in Transporting Individuals with Severe Mental Illness, A National Survey.*
https://www.treatmentadvocacycenter.org/storage/documents/Road-Runners.pdf
[52] Eide, S., & Gorman, C. D. (2021). *Medicaid's IMD Exclusion: The Case for Repeal.* Manhattan Institute.
https://media4.manhattan-institute.org/sites/default/files/medicaids-imd-exclusion-case-repeal-SE.pdf
[53] The Front End Project. (2021). *From Harm to Health: Centering Racial Equity and Lived Experience in Mental Health Crisis Response*. Fountain House. https://fountainhouse.org/assets/From-Harm-to-Health-2021.pdf
[54] For more information, see: https://mmhpi.org/project/right-care/

Traditional Versus Reformed 911 Response With the Dallas RIGHT Care Model
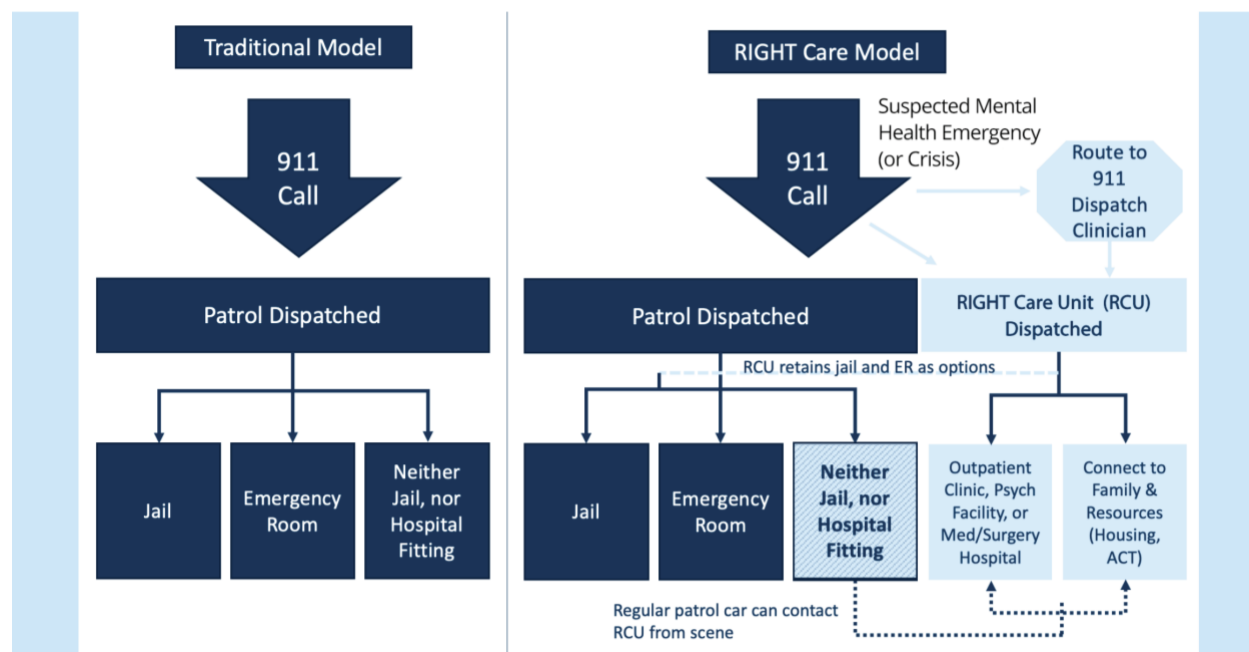
Texas is also implementing best practices to plan and coordinate 911 response, crisis response, and the broader mental health and substance use disorder treatment systems. A particular best practice is San Antonio's Southwest Texas Crisis Collaborative (STCC). STCC works operationally within the Southwest Texas Regional Advisory Council (STRAC), which coordinates emergency medical response for all health needs (including COVID-19) in the 22-county region surrounding San Antonio. STCC is now facilitating plans with the City of San Antonio, Bexar County, and mental health and substance use stakeholders to maximize the impact of COVID-19 relief funds and the American Rescue Plan to address mental health and substance use service needs, including housing, trauma response, and other social determinants.[55]

Congress can and should incorporate broader 911 reform, in addition to continued support for the development of 988 crisis response and community treatment capacity. STCC also offers a local model for the cross-agency planning and coordination recommended above.

Improve Health Equity

Pre-dating the pandemic, Black, Indigenous, and other people of color across America faced systemic challenges accessing mental health care, with nearly three-quarters (73%) of Asians and Pacific Islanders, 69% of Blacks, and 67% of Latinos with mental illness not receiving

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[55] For more information on STCC and STRAC, see: https://www.strac.org/stcc

needed mental health treatment.[56] Also prior to the pandemic, Black and Latino people were less likely to receive needed behavioral health services compared to the general population, and they are more likely to receive low-quality care.[57] Earlier in my testimony, we documented how COVID-19 has worsened these pre-pandemic inequities. All of the Texas-based reforms highlighted in my testimony – CPAN and TCHATT for children, Cloudbreak and CoCM for primary care based treatment more broadly, and MDRT-based 911 reforms – are all focused on addressing health inequities disproportionately impacting Black, Latino, and other Texans of color. Congress should continue to require specific metrics related to eliminating these inequities in all actions going forward, similar to requirements in the American Rescue Plan.

Improve the Primary and Specialty Care Workforce

Major deficiencies in the mental health and substance use disorder workforces are well documented, and two strategies being implemented in Texas are offered for further consideration. The first is simply the broad focus on primary care integration noted throughout my testimony. Primary care is the front line for the heart disease and cancer treatment workforce, and the strategies I noted earlier to expand the reach of primary care for mental illness and addiction are force multipliers for the behavioral health workforce.

We also need to expand the specialty workforce through peer specialists and community health workers with a broad emphasis on lived experience. As part of our Cloudbreak Initiative in North Texas, we are partnering with the Department of Global Health and Social Medicine at Harvard Medical School to deploy their EMPOWER program in North Texas in 2021 and with a Latino cultural adaptation in 2022. EMPOWER builds on path-breaking research demonstrating how non-specialist care providers can be trained and supervised to deliver brief psychological treatments for depression with just as much effectiveness as specialist-delivered treatment protocols.[58] This program greatly increases accessibility to mental health care because the care is delivered by community health workers (CHWs) who live and work with (and often share similar lived experience with their neighbors living in) marginalized communities that are currently underserved. Building on a decade of implementation research in India, we are on track to deploy EMPOWER to better expand the North Texas workforce to better reach

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[56] Chaves, K., Gray, D., Barton, B., Bonnett, D., Azam, I., Hahn, C., Goldstein, E., Hall, I., Harris, N., Muhuri, P., King, J., Lankford, A., Lau, D., Liang, L., Liu, S., Matosky, M., Matthews, T., Morgan, R., Moser, R., … Valentine, M. (2020). *2019 National Healthcare Quality and Disparities Report*. Agency for Healthcare Research and Quality. https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrdr/2019qdr.pdf

[57] Snyder, C. R., Frogner, B. K., & Skillman, S. M. (2018). Facilitating Racial and Ethnic Diversity in the Health Workforce. *Journal of Allied Health*, *47*(1), 58–65. https://pubmed.ncbi.nlm.nih.gov/29504021/

[58] Patel, V., Weobong, B., Weiss, H. A., Anand, A., Bhat, B., Katti, B., Dimidjian, S., Araya, R., Hollon, S. D., King, M., Vijayakumar, L., Park, A.-L., McDaid, D., Wilson, T., Velleman, R., Kirkwood, B. R., & Fairburn, C. G. (2017). The Healthy Activity Program (HAP), a lay counsellor-delivered brief psychological treatment for severe depression, in primary care in India: A randomised controlled trial. *The Lancet*, *389*(10065), 176–185. https://doi.org/10.1016/S0140-6736(16)31589-6

communities of color and people living in poverty more broadly in late 2021. EMPOWER addresses the formidable barriers of training, supervision, and quality assurance with a suite of digital tools to train, supervise, and equip the CHWs to consistently deliver evidence-informed care.

We Must Apply the Lessons of the Pandemic to Address the Epidemic

In less than a year, America showed the world that we can learn now to detect, treat, and prevent a disease that we had never before seen. Over the last year in Texas, we have shown that rapid progress is both possible and broadly scalable for the longer standing scourges of suicide, overdose, and mental illness and addiction more broadly.

I am deeply grateful to the Committee for the opportunity to share information about these strategies, and I look forward to supporting the work of the Senate and the Administration to turn the tide on mental illness and addiction, just as we have for COVID-19 in the last year, and heart disease and cancer over the prior two decades, through early detection, evidence-driven and equitable care, and the will to implement known treatment approaches while we also continue to research even better care.