Statement of Jennifer Lockman, PhD

Chief Executive Officer, Research Institute

Centerstone America

Before the

U.S. Senate Committee on Health, Education, Labor & Pensions

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

Tuesday, February 1, 2022

Testimony of Dr. Jennifer Lockman, CEO, Research Institute

Centerstone America

U.S. Senate Committee on Health, Education, Labor & Pensions

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

I would like to thank Chair Murray and Ranking Member Burr and this committee for your dedication to seeking solutions to the growing mental health and substance use crisis our country is facing today. I'd also like to thank Senator Braun for his leadership for the state of Indiana, which is one of the states we are proud to serve in. I'm honored to be here as the voice of my colleagues at Centerstone and most importantly on behalf of the people we serve.

Centerstone is the nation's largest nonprofit mental health company. Centerstone provides community-based behavioral health care, substance-abuse treatment, and intellectual and developmental disabilities services in Florida, Illinois, Indiana, and Tennessee. At Centerstone's Research Institute (CRI), a Centerstone company, we conduct research to prevent and cure mental illness and addiction. We also work to translate data into meaningful clinical tools and practices, thereby reducing the research-to-practice gap.

We applaud this hearing today because unfortunately, deaths due to suicide, overdose, and drug and alcohol related disease are all too prevalent. As of 2020, suicide was the 12th leading cause of death in the United States for adults, and the 3rd leading cause of death for youth. For every suicide death, there are approximately 1.1 million suicide attempts, or about one every 27.5 seconds (Drapeau & McIntosh, 2021). Between 40% to 50% of Americans have been exposed to suicide during their lifetime (Cerel et al., 2014; Feigelman et al., 2017). This means that at least half of us sitting in this room today are likely to have been personally affected by the

loss of someone we loved to suicide. Although suicide deaths *decreased* approximately 3.4% between 2019 and 2020, perhaps due to a "pulling together effect" we have seen before during national crises, the deeply painful impact of suicide deaths on American individuals, families, and communities remains high (Drapeau & McIntosh, 2021; Joiner et al., 2006).

For this reason, Congress in partnership with the Substance Abuse and Mental Health Services Administration (SAMHSA) created the Garrett Lee Smith, National Strategies for Suicide Prevention, Zero Suicide, and Covid-19 Emergency Response suicide prevention grants. Centerstone's healthcare system is honored to share our experience and the outcomes from some of the SAMHSA grants that we have received.

Through our Zero Suicide SAMHSA grant, we are now working to spread evidence-based practices known to decrease suicide throughout our entire health system, and using data to make them even better. For example, we have updated our Suicide Prevention Pathway to ensure everyone in our healthcare system gets evidence-based suicide screening, risk management, and treatment. We have moved toward a new screening system that first asks about more "upstream" risk factors for suicide (such as thwarted belongingness, perceived burdensomeness, and acquired capability for suicide; Joiner et al., 2005), and then asks about suicide directly (PHQ-9; C-SSRS). We anticipate this screening process helps us identify and treat drivers of suicide risk earlier, with better outcomes (Louzon et al., 2016: Richards et al., 2019).

We have also piloted a suicide prevention specialty care clinic, the first known in Community Mental Health Centers in the United States. We expect all of our Centerstone clinicians to be able to identify and treat suicide risk; however, it is difficult and costly to keep all of our clinicians up to date on suicide-specific treatments as fast as the science changes. In medicine, we have seen that people often get better outcomes at cost, when at high risk, by

seeing medical specialists (e.g., cardiologists, oncologists). Thus, through our grant, we are creating a referral system so that persons at the highest risk for suicide can be seen by providers who are trained in multiple suicide-specific treatments – the best that science has to offer.

Our grants have also provided a Crisis follow-up program to youth and adults during care transitions from inpatient facilities, a high-risk period for suicide attempts and re-attempts (Chung et al., 2017). Our data suggest this program helps individuals re-establish connectedness, decrease their sense of burdensomeness, reduce suicidal ideation, and successfully link to outpatient care (70-90% of the time). These services would be unbillable, and impossible, without the federal SAMHSA grants. Knowing this program works to save lives is especially timely given the July 2022 launch of "988" as the three-digit dialing code for the National Suicide Prevention Lifeline (NSPL). As we look toward launching 988 we must also continue to evaluate strategies to ensure these data-supported services are funded and available nationally. This is why we also support the Behavioral Health Services Crisis Expansion Act (S. 1902) as a crucial component to financing a crisis care continuum.

Another grant program that has been a lifeline is the Certified Community Behavioral Health Clinic (CCBHCs) Medicaid demonstration and CCBHC SAMHSA grant program. CCBHCs allow consistent care for those with mental health or substance use conditions and a place to go in times of crisis. This model is helping to address some of the dire workforce challenges our field has faced even prior to the pandemic. We recommend continued investment in the CCBHC program. Centerstone is also pleased to be one of only a few Comprehensive Opioid Recovery Center grant recipients in the nation. We administer this grant in Indiana, where we were able to train over 467 professionals in evidence-based practices and open a recovery house for women. We recommend continued investment in this promising program.

Of all the things you might take away from my testimony today please be sure to hear this: Federal funding works. Federal funding helps prevent suicide and substance-related deaths, uses program evaluation to help make programs better, and helps individuals recover and contribute in their communities. Thus, it's critically important that future federal grants to require evidence-based programs and data-driven program improvements. It has been one of the great joys of my life to watch our SAMHSA grant programs help individuals who previously did not want to live, re-build a life based on their values, talents, and strengths, often overcoming psychosocial barriers and past trauma to do so. In the words of one of our clients: *"There's no way to define a future if you are not there for it. And everyone is really focused on making sure that you stay there for it, stay alive, stay safe. It's been really helpful for me to develop my own path, and feel supported, but feel directed in ways that need to be. It's made a lot of difference."*

Thank you, and I look forward to your questions.

January 30, 2022

The Honorable Patty Murray
Chair
Senate HELP Committee
154 Russell Senate Office Building
Washington, DC 20510

The Honorable Richard Burr
Ranking Member
Senate HELP Committee
217 Russell Senate Office Building
Washington, DC 20510

RE: Full Committee Hearing on Mental Health and Substance Use Disorders: Responding to the Growing Crisis (*Written Testimony – Long Version*)

I would like to thank Chair Murray and Ranking Member Burr and this committee for your dedication to seeking solutions to the growing mental health and substance use crisis our country

is facing today. I'd also like to thank Senator Braun for his leadership for the state of Indiana, which is one of the states we are proud to serve in. I'm honored to be here as the voice of my colleagues at Centerstone and most importantly on behalf of the people we serve.

At Centerstone's Research Institute (CRI), we conduct research to prevent and cure mental illness and addiction. We also work to translate research into meaningful clinical practices and implement research-based strategies in real-world settings, thereby reducing the research-to-practice gap. CRI's workforce is interdisciplinary and comprised of Physicians, Psychologists, Dissemination and Implementation Scientists, Counselor Educators, Program Evaluators, Social Workers, Public Health Advisors, Biostatisticians, Clinical Transformation Specialists, Design Thinking Experts, and others. Centerstone's Research Institute is a company of Centerstone, the nation's largest nonprofit mental health company who provides community-based behavioral health care, substance-abuse treatment and intellectual and developmental disabilities services in Florida, Illinois, Indiana, and Tennessee.

We applaud this hearing today because unfortunately, our rates of deaths of despair are rising. Deaths of despair are deaths by suicide, overdose, and disease due to excessive drug or alcohol use. Over the last 10 years, deaths of despair have increased nearly twofold to over 185,000 deaths in 2020 (CDC, 2022). Deaths of despair have increased so drastically that they have substantially impacted our life expectancy in the United States in 2015, marking the first decrease in life expectancy in decades; all of this occurring BEFORE the pandemic.

Today, mental health and addiction services are needed now more than ever as the COVID-19 pandemic has increased the prevalence and incidence of behavioral health disorders in adults and children/adolescents. Nationwide, 2020 was the deadliest year on record for fatal overdoses.[1] Within the pediatric population – children's emergency room visits related to mental health spiked dramatically – up 24 percent for kids 5 to 11 years old and 31 percent for teenagers 12 to 17 years old.[2] Even before the pandemic, 75 percent of U.S. counties experienced severe shortages of mental health providers.[3] As demand for behavioral health services continues to rise, and workforce challenges increase, providers around the nation are struggling to meet the demand.

As one of the nation's leading not-for-profit providers of behavioral health – we are acutely aware that mental health and substance use disorder challenges are a growing concern within our communities. We see it with our teachers, healthcare workers, our firefighters and police, our returning military service personnel, and our own families. To this end, in addition to our oral testimony, we offer several policy recommendations to address the nation's growing behavioral health needs that we believe are realistic, bipartisan, and aligned with the best science of care.

I. Advancing the best science of care relative to suicide prevention and intervention; particularly as the nation prepares to launch 9-8-8 in July of 2022

[1] https://www.politico.com/news/2021/07/14/covid-pandemic-drug-overdoses-499613
[2] https://www.cdc.gov/mmwr/volumes/69/wr/mm6945a3.htm
[3] Macher, D., Seidman, J., Gooding, M., & Diamond, C. (2020, May 11). COVID-19 is Stressing a Fractured Mental Healthcare System in the US. https://avalere.com/insights/covid-19-is-stressing-a-fractured-mental-healthcare-system-in-the-us.

In 2020, nearly 46,000 people died by suicide a slight decrease from the year before. However, this doesn't tell us the whole story. Deaths of despair have been rising dramatically in the US over the past decade. Deaths of despair is defined as all deaths by suicide, overdose, and disease due to excessive drug or alcohol use; it is a term often used because of their shared underlying factors and the difficulty to parse apart one death from the other (that is, suicides are often misclassified as overdoses). Over the last 10 years, deaths of despair have increased nearly twofold to over 185,000 deaths in 2020 (CDC, 2022). Deaths of despair have increased so drastically that they have substantially impacted our life expectancy in the United States in 2015, marking the first decrease in life expectancy in decades; all of this occurring BEFORE the pandemic (see table 1 and table 2).

Table 1

What is a Death of Despair (DoD)

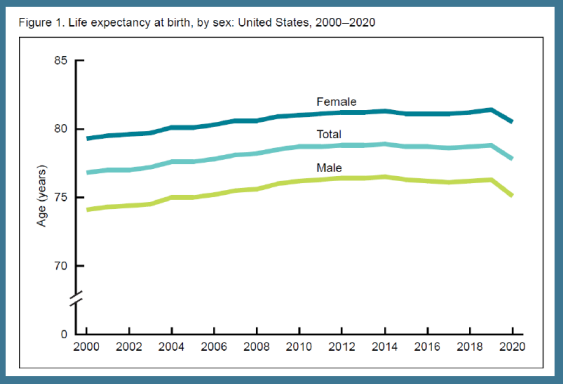
Deaths of despair are deaths directly related to substance misuse (i.e., alcohol abuse or overdose) and suicide.

DoDs outpace cancer and car crashes when adjusting for age (CDC, 2021).

Over 185,000 deaths in the United States in 2020 (45,855 suicides, 100,306 overdoses, ~39,000 alcohol related liver disease)

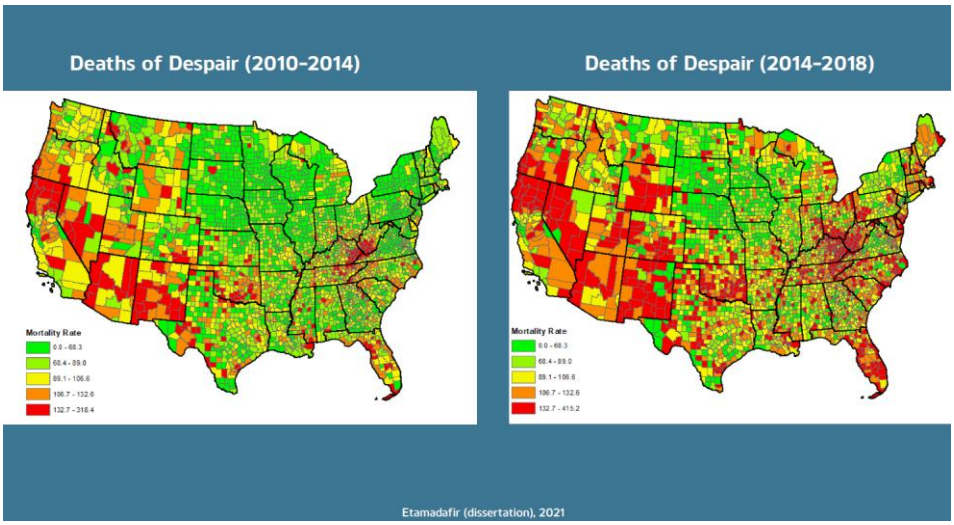
~5,000,000 years of lives lost in the United States in 2020 due to DoD (calculated rates utilizing Gomes et al, 2018)

DoDs have significantly impacted life expectancy over recent years, even BEFORE the pandemic (starting in 2015).



CDC, 2021

Table 2



In response to these alarming trends, Congress in partnership with the Substance Abuse and Mental Health Services Administration (SAMHSA) created the Zero Suicide Initiative and other grant programs aimed at suicide prevention. Indeed, research suggests that up to 90% of individuals at risk for suicide interact with healthcare systems within the year before there death, such that healthcare systems are an ideal place for suicide prevention and treatment (Ahmedani et al., 2019). Centerstone's healthcare system is honored to share our experience and the outcomes from some of the SAMHSA grants that we have received. I hope to illustrate that through national funding efforts, evidence-based practices, and data-driven program innovation, suicide deaths can be *prevented.*

Through our Zero Suicide SAMHSA grant, we are now using existing evidence-based practices known to decrease suicide throughout our health system, and using data to make them even better. For example, through our grant, we have updated our Zero Suicide Pathway to ensure everyone in our healthcare system gets evidence-based suicide screening, risk management, and treatment. Specific to suicide screening, we have realized through Centerstone data surveillance that the Columbia Suicide Severity Rating Scale (C-SSRS; Posner et al., 2011) works well at identifying many people who are suicidal and need care– but does not identify a group of individuals who may be most likely to die by suicide. For this reason, we have moved toward a new screening system that first asks about more "upstream" risk factors for suicide (such as thwarted belongingness, perceived burdensomeness, and acquired capability for suicide; Joiner et al., 2005), and then asks about suicide directly (PHQ-9; C-SSRS). In this way, we are building on the existing evidence to cast a "wider net," to potentially prevent and treat drivers of suicide risk earlier in the course of illness, and identify a unique cohort of individuals who may be at the highest risk for suicide who may not disclose if asked directly (Louzon et al., 2016: Richards et al., 2019).We were able to find this out due to data monitoring strategies enacted with Zero Suicide funding. As a result, we are able to apply lessons learned from this data by going upstream, testing new research ideas and asking different questions that target the DRIVERS of suicidal thinking (i.e., disconnection, burdensomeness) but not suicidal thinking directly.

Through our Zero Suicide SAMHSA grant, we have also piloted a suicide prevention specialty care clinic, the first known in Community Mental Health Centers in the United States. Whereas we expect all of our Centerstone clinicians to be able to identify suicide risk, manage risk at the appropriate level of care, and know at least one frontline evidence-based treatment for suicide, we realize it is difficult and costly to train all of our providers in multiple suicide-specific treatments and keep them up to date as fast as the science changes. In medicine, we have seen that people often get better outcomes at cost, when at high risk, by seeing a medical specialists (e.g., cardiologists, oncologists). It is possible, then, that the same may be true for suicide risk. Through our grant, we are creating a referral system to where persons at the highest risk can be seen by providers in our specialty clinic for their care. Our providers in this clinic have been well-trained in over six, modern, evidence-based, suicide-specific treatments and are well-equipped to manage high risk conditions and co-occurring diagnoses. Thus far we've had really great feedback and outcomes – both from the clinicians we've trained as well as the clients we're serving. As one of our clinicians stated recently: "My perspective on suicide prevention has changed significantly since I started being part of this clinic. . . I believe being part of this [specialty] clinic has helped me gain confidence in treating clients, reduced the fear in treating

suicidal ideation/behavior, and start to have in-depth . . . conversations with clients about how to manage their crisis and explore steps toward a life worth living."

An additional area where we've applied our Zero Suicide funding is what is referred to as *"implementation science."* We know that a lot of treatments that are studied in the lab or university – as great as they are – once you put them in a real-world environment often times do not work in the way they were designed. This is because there are systems level barriers to where it may be harder to use those therapies or treatments in the ways that were studied. Implementation science helps us to truly understand how these approaches are implemented and how we can navigate workflow challenges and other community-level barriers to change our treatments so that they can be modified to truly work in real world practice settings.

We have also participated in several SAMHSA grants, such as the Garrett Lee Smith and National Strategy for Suicide Prevention Grants (GLS; NSSP) that have allowed us to provide suicide crisis follow-up services to adults and youth. Research suggests that individuals discharged from emergency departments and inpatient units are at high risk for suicide and often experience difficulty linking to outpatient care services (Chung et al., 2017). Our Crisis Follow-up Program provides phone calls to clients and a supportive phone app within the four weeks post-discharge. Our program uses an evidence-based framework (Joiner et al., 2005) to help adults and youth re-establish a sense of connectedness to others, re-discover and apply their talents and life values - such that they don't feel that they are a burden to others, monitor their suicide risk using a phone app, and successfully link to outpatient care. Data outcomes from our program suggest statically significant and clinically meaningful outcomes, including reductions in suicidal ideation, increases in self-efficacy to prevent suicide, and that between 70% to 90% successfully link to outpatient care (compared to the national average of 40%). It's critically important to note that, because adults and youth in this program are experiencing care transitions, these services provided to them would be <u>unbillable</u>, and impossible, without the federal SAMHSA grants. Knowing this program works is especially timely given the July 2022 launch of "988" as the three-digit dialing code for the National Suicide Prevention Lifeline (NSPL).

As we look toward launching 988 we must also continue to evaluate strategies to ensure these data-supported services are funded and available nationally, this is why we also support the Behavioral Health Services Crisis Expansion Act (S. 1902) as a crucial component to financing a crisis care continuum. With appropriate funding and resources – we know we can prevent deaths and save lives. That's why this grant is so important. Additionally, we encourage Congress's consideration of longer term, more sustainable financing mechanisms.

As we look toward launching 988, we must continue to evaluate strategies to ensure these data-supported services are funded and available nationally. To that end, we recommend:

- ✓ Passage of the *Behavioral Health Services Crisis Expansion Act (S. 1902)* as a crucial component to financing the crisis care continuum; and

- ✓ That the final Conference Report for the FY2022 Labor-HHS Appropriations bill include:

- 10% set-aside for mental health crisis systems in the Mental Health Block Grant (MHBG) program;
- $100 million to establish the Mental Health Crisis Response Partnership Pilot Program to help communities create mobile crisis response teams that divert the response for mental health crises from law enforcement to behavioral health teams; and
- $375 million to provide grants to Certified Community Behavioral Health Clinics (CCBHCs) to provide treatment for those with mental health illness.

Ultimately, we believe that our nation's ability to respond to behavioral health crises in the same way we respond to other medical emergencies – with prompt, effective, and culturally competent care – is essential to our collective well-being. With the new three-digit crisis number becoming universally available in July 2022, it is essential to act quickly to fund and implement important components of the overall 988 system.

II. Addressing the behavioral health workforce shortage, while increasing care integration/access

There are other community behavioral health and substance use disorder grants that have also made a meaningful impact on the people we serve. For example, a program that has been a lifeline is the Certified Community Behavioral Health Clinic (CCBHCs) Medicaid demonstration and CCBHC SAMHSA grant program. Our CCBHC program also allowed us, when the COVID-19 Pandemic hit, to examine if our clients were getting good outcomes via tele-health and phone compared to face-to-face treatment. Our evidence indicated they were, which has increased our continued application of telehealth throughout our operations to ensure patient access and outcomes.

On the whole, Certified Community Behavioral Health Clinics (CCBHCs) can play a transformative role in addressing historically dire workforce shortages, creating a more seamless/integrated care delivery system, and bolstering the nation's 988 preparedness; all while ensuring providers meet quality metrics. Specifically, these entities are designed to provide a comprehensive range of mental health and substance use disorder services to vulnerable individuals in a single location. CCBHCs are responsible for providing nine types of services, implementing evidence-based practices, coordinating care, and integrating with physical healthcare services. To date, there are two types of this model – the grantees, which are in the pilot phase, and CCBHC Medicaid demonstration sites which have permanently expanded the model and adopted a new payment methodologies, more akin to the FQHCs, to support on-going services.

<u>Nationally, the CCBHC model has generated the following outcomes.</u>

*Indiana Outcomes (*Pilot/Grantee Phase)*

The CCBHC model in Indiana has helped ensure positive outcomes among Centerstone clients, including:

- 73% of adult clients reported little/no depressed feelings

- 93% reduction of clients hospitalized for mental health reasons in previous 30 days
- 100% reduction of clients who utilized an emergency room for behavioral health issues in previous 30 days
- 64% increase in adult clients reporting their symptoms were not bothering them

*Illinois Outcomes (*Pilot/Grantee Phase)*

The CCBHC model in Illinois has helped ensure positive outcomes among Centerstone clients, including:

- 50% decrease in homelessness
- 60% reduction of clients who utilized an emergency room for behavioral health
- 50% decrease in nights spent in jail

New York

- New York officials reported that CCBHCs had a 54% decrease in the number of individuals using inpatient behavioral health services, which translated to a 27% decrease in associated monthly costs.

Texas

- The CCBHC model in Texas is projected to save $10 billion by 2030;
- In 2 years, there were no wait lists at any CCBHC clinic; and
- 40% of clients treated for co-occurring SUD and SMI needs, compared to 25% of other clinics

Missouri

- Overall access to mental health and addiction treatment services increased 23% in 3 years, with veteran services increasing 19%; and
- Missouri found a 76% reduction emergency room visits and hospitalizations where CCBHCs were embedded in those facilities. In those same CCBHC areas, Missouri law enforcement saw a 55% decrease in interactions with people with behavioral health conditions.

Additionally, data from providers across the nation has found that the CCBHC model significantly addresses workforce challenges.[4]

Specifically, the payment methodology associated with CCBHCs allows providers to reimburse for services they may not have a direct reimbursement for – i.e., assistance with addressing social determinants of health, robust care coordination, crisis services, and covering positions (i.e., peer support specialists) that may not be recognized by all payer types, etc. Many of these non-billable services and provider types are critical in providing coordinated care that results in increased patient outcomes as well as a financial model that supports the existing workforce.

- It's estimated that as of January 2021 CCBHCs added 9,000 new positions nationwide; and

- On average, this resulted in 41 new jobs per clinic.

Given the growing need for improved access, bolstered workforce, and assurances that consumers received evidenced based treatments; **we support the passage of *The Excellence in Mental Health and Addiction Treatment Act of 2021 – S. 2069*** led by Senators Stabenow (D-MI) and Blunt (R-MO) which would allow every state the option of joining the innovative Certified Community Behavioral Health Clinic (CCBHC) Medicaid demonstration and authorize grant (pilot) investments in the model for current and prospective CCBHCs.

II. Expanding access to telehealth services for behavioral health care

While we applaud inclusion of the telemental health services provision in the December 2020 end of year COVID relief package (*Consolidated Appropriations Act of 2021, Section 123*), we believe putting service restrictions on telehealth access for mental health services through in-person requirements undercuts the very tenets around the flexibility and access afforded by telehealth and other virtual care modalities. For example, under this new rule a beneficiary who – during the PHE was seeing a provider several hours from their home via telehealth - will have to now see their provider in-person, at least one time per year, to maintain continuity of care after the pandemic. This will most certainly delay or fully eliminate access to care for some consumers. Furthermore, the new requirement for an in-person visit applies *only* to mental health treatment, whereas Medicare beneficiaries seeking treatment for substance use disorder (SUD) via telehealth are not subject to this requirement. Given the elevated occurrence of SUD with mental health comorbidities, and recent reports indicating that 2020 was the deadliest year for overdoses,[5] this requirement ultimately creates new barriers which could result in significant delays in access to lifesaving care. Lastly, this requirement will further encumber already overworked providers to

[4] https://www.thenationalcouncil.org/wp-content/uploads/2021/05/052421_CCBHC_ImpactReport_2021_Final.pdf?daf=375ateTbd56 (p. 7)
[5] https://www.politico.com/news/2021/07/14/covid-pandemic-drug-overdoses-499613

arbitrarily delineate between their patients on "who gets what type of service" based on diagnosis, rather than clinical presentation and best practice. This approach is counter to the gold standard of providing the "right care at the right time" to improve patient and population health outcomes.

With regard to program integrity - telehealth, by design, is a transparent and accountable means of care delivery. Technology platforms that provide telehealth are currently capable of capturing a range of data points from telehealth and telephonic encounters that can offer transparency to the delivery of virtual care and protect against fraudulent actors. Unlike in-person care, telehealth encounters conducted over platforms such as Electronic Health Records (EHRs) or other tech-enabled landscapes that automatically capture the time call took place, duration, patient information, and other details that can be used to strengthen compliance efforts. As long as the provider is utilizing a technology platform that records relevant data, it does this for every connection – making the engagements recordable, auditable, and actionable.

In order to address this telemental health access gap, we recommend passage of *The Telemental Health Care Access Act - S. 2061 led by Senators. Smith (D-MN), Cassidy (R-LA), Cardin (D-MD), and Thune (R-SD)*. The Telemental Health Care Access Act would provide continuity in behavioral health care access by removing the statutory requirement that Medicare beneficiaries be seen in person within six months of being treated for a mental health service via telehealth.

In summary, federal funding works. Through these grants, our clients are establishing safer, better lives they are wanting to live, and we couldn't provide this treatment without these grants. We need to continue to ensure that SAMHSA grants require the implementation of evidenced-based services, so we can test these models and iterate based on lessons learned. Additionally, we need to look toward nation-wide, sustainable means of funding for areas where the data has indicated need and benefit to consumers. Broadening insurance and telehealth coverage for the full continuum of behavioral health services – and, in particular, crisis care - as well as advancing CCBHCs can play a transformative role in meaningfully addressing our nation's growing behavioral health crisis.

Thank you for your continued focus on this important matter, if there are any additional questions and/or data we might be able to provide – please do not hesitate to reach out by contacting either myself or Lauren Conaboy, VP of National Policy, Centerstone at lauren.conaboy@centerstone.org.

Sincerely;

Jennifer D. Lockman, PhD
CEO
Centerstone Research Institute