AMERICAN PSYCHIATRIC ASSOCIATION

800 Maine Avenue, S.W.
Suite 900
Washington, D.C. 20024

Testimony of Jeffrey L. Geller, MD, MPH

on behalf of

The American Psychiatric Association

Before the U.S. House of Representatives

Health Subcommittee of the House Energy and Commerce Committee

LEGISLATIVE HEARING:

High Anxiety and Stress: Legislation to Improve Mental Health During Crisis

June 30, 2020

Chairwoman Eshoo, Ranking Member Burgess, and distinguished members of the Energy and Commerce Health Subcommittee, thank you for allowing me the opportunity to serve on today's panel. My name is Dr. Jeffrey Geller, I am currently a Professor of Psychiatry at the University of Massachusetts Medical School and a staff psychiatrist at a 290-bed public psychiatric hospital in central Massachusetts. I have been an expert for the U.S. Department of Justice and for 26 states, visiting all of them, usually multiple times, to evaluate state hospitals and mental health systems of care. Throughout the COVID-19 pandemic, I have gone into work most weekdays to treat severely mentally ill patients and see outpatients through telepsychiatry.

I am also a parent. One of my sons, who has intellectual disabilities, goes to work daily at Brigham and Women's Hospital in Boston where he delivers medical supplies throughout the hospital. I have been much more concerned about his wellbeing than I have about my own. I'm testifying today in my capacity as President of the American Psychiatric Association (APA), on behalf of the 38,800 psychiatrists we represent.

The APA is dedicated to providing our physician members with education and training on the most modern evidence-based treatment to diagnose and treat patients with mental health and substance use disorders (SUDs). The APA and its members are focused on the clinical treatment of patients with mental health and SUDs, and our members are also quite active in pursuing policies that affect our patients' access to quality care. APA works in partnership with many mental health organizations and patient advocates on the issues that are the subject of this hearing today: mental health parity compliance, mental health access and treatment in schools, telehealth, emergency room psychiatric crisis diversion, suicide prevention, health

disparities and mental health research. Given the deep understanding that psychiatrists have of mental health and complex cooccurring medical conditions, as well as our perspectives on what our patients deal with as they attempt to access care, we are in a unique position to assist the Committee with a wide-ranging perspective related to the multitude of subjects on which this hearing will focus.

Before I discuss legislative issue areas that you are considering, I would like to start off with some statistics on the state of our country's mental health system, especially in the context of the COVID-19 pandemic. The state of our mental health care system has been dire for quite some time now. Before the arrival of COVID-19, the suicide and opioid epidemics were responsible for killing over 100,000 Americans annually. Pre-COVID-19, the suicide rate was the highest it has been since the second World War and the opioid overdose rate continued to claim 128 lives every single day in 2018.[1] In addition, data show that 47.8 million Americans aged 18 and older have a mental illness[2] and suicide rates are on the rise, especially among young Americans ages 15 to 25.[3] In addition, we have seen an alarming trend in Black communities where Black children have the highest rates of suicide, rising from 2.55 per 100,000 in 2007 to 4.82 per 100,000 in 2017.[4]

In the COVID-19 pandemic era, Americans are now grappling with one of the worst unemployment rates in recent history, added to social isolation in order to comply with physical

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[1] https://www.drugabuse.gov/drug-topics/opioids/opioid-overdose-crisis

[2] Substance Abuse and Mental Health Services Administration. (2019). Key substance use and mental health indicators in the United States: Results from the 2018 National Survey on Drug Use and Health (HHS Publication No. PEP19-5068, NSDUH Series H-54). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/

[3] Curtin SC, Hedegaard H. Suicide rates for females and males by race and ethnicity: United States, 1999 and 2017. NCHS Health E-Stat. 2019.

[4] https://watsoncoleman.house.gov/uploadedfiles/full_taskforce_report.pdf

distancing recommendations and topped off with the unfolding communal unrest regarding systemic racism and police brutality. Each of these situations alone would generally increase the feelings of anxiety, depression and other mental health and SUDs for many Americans. When combined, these factors produce alarming statistics.

A Mental Health America (MHA) online survey[5] showed that in mid-to-late February 2020, more than 88,000 more Americans have screened positively for anxiety or depression compared to normal expectations (using November 2019 to January 2020 averages as a baseline) before the pandemic. The same study found that about ten percent of the over 211,000 people who took the online survey indicated that they had contemplated suicide or harming themselves. These symptoms of increased anxiety, depression and self-harm are attributed to the COVID-19 pandemic, a public health emergency that has killed more than 120,000 Americans. The MHA study also found that these mental health concerns are more pronounced in young people under age 25, with almost 9 out of 10 patients screening positively in the moderate-to-severe depression range, and 8 out of 10 screening positively with moderate to severe anxiety.

The APA also conducted our own study[6] in March of this year and found that nearly 48% of Americans were anxious about the possibility of contracting COVID-19, and almost four in ten Americans, or 40%, are anxious about becoming ill or dying of COVID-19. The study also found that more than 62% reported being anxious about the possibility of family and loved ones contracting COVID-19. In addition, our survey found that more than one third, or 36%, of

[5] https://mhanational.org/sites/default/files/Coronavirus%20Mental%20Health%20Presentation%206-1-2020.pdf
[6] https://www.psychiatry.org/newsroom/news-releases/new-poll-covid-19-impacting-mental-well-being-americans-feeling-anxious-especially-for-loved-ones-older-adults-are-less-anxious

Americans felt that the virus was having a serious impact on their mental health and most, or 59%, felt that the virus is having a serious impact on their day-to-day lives. Finally, 57% of adults surveyed were concerned that the virus would have a serious negative impact on their finances. Almost half reported being worried about running out of food, medicine, and/or supplies and two-thirds, or 68%, reported fear that the coronavirus will have a long-lasting impact on the economy.

These statistics are deeply troubling, but not overly surprising, given the additional stressors placed upon each American in the current COVID-19 climate. In addition, as the pandemic continues and hopefully begins to wind down, the mental health community is worried about the so-called 'second wave,' of mental illness. There will likely be a subsequent mental health pandemic of what we fear will be of epic proportion if we do not take comprehensive action to increase quality and access while reducing the barriers and cost of mental health and substance use services.

That being said, I am not here today to say that the situation is hopeless, because it is not. I am pleased to say that the APA supports almost all the pieces of legislation that are part of today's hearing, which take useful steps in the right direction. As such, I would now like to delve into some of today's focus areas.

Health Disparities, Data Collection and Research

The APA appreciates the work Congress has done to ensure access to vital health services for all communities during the COVID-19 public health emergency. However, there is more to be done, as preliminary data show that the COVID-19 virus disproportionately impacts minority and vulnerable populations. We cannot begin to remedy systemic issues within health

care access and delivery if we do not first have quantifiable data from which to inform our policy proposals. Access to this type of information would empower healthcare providers to allocate the resources to get culturally appropriate information and care to affected individuals in underserved communities. We encourage the Committee to examine policies that require the Department of Health and Human Services (HHS) to collect, analyze, and make available to the public, explicit, comprehensive, standardized data on race and ethnicity related to the testing availability and related morbidity results, hospitalization, and mortality associated with COVID-19. As such, APA has endorsed, and is pleased to see the Committee considering legislation like H.R. 5469, the *Pursuing Equity in Mental Health Act of 2019* introduced by Rep. Watson Coleman (D-NJ) and H.R. 6645 introduced by Rep. Paul Tonko (D-NY) on today's list of legislation. These bills include beneficial policies that require HHS to collect data on and support research regarding the mental health consequences of COVID-19 and establish grant programs to support increasing research on disparities at the National Institutes of Health as well as increasing funding for the SAMHSA Minority Fellowship Program. All these proposals are all vitally important to better our understanding of health needs through data which fosters more appropriate delivery of essential mental health care.

Mental Health Parity

The APA has advocated for mental health parity for many years and applauded Congress when it passed the *Mental Health Parity and Addiction Equity Act* of 2008. This landmark, bipartisan legislation was designed to end the discriminatory health insurance practices individuals with mental illnesses and SUDs have encountered for decades. However, a dozen years later, it is clear that true parity has not been achieved. Numerous investigations by state

regulators and the Department of Labor have revealed systemic parity violations in virtually every investigation. Most of these violations involve medical management techniques, such as prior authorization, that are more restrictive for mental health and SUD treatment than for other medical care. This directly inhibits access to care and leads to increased risk of death from overdose and suicide.

State legislatures have been active in addressing these continued parity violations by enacting legislation requiring insurers to submit parity-compliance reports to state regulators, with 12 states passing essentially identical bills since 2018. These states range from Republican-controlled states such as Arizona, Indiana, West Virginia and Oklahoma, to Democratically-led states such as Colorado, Illinois, Maryland and New Jersey. We encourage the Committee to take similar bipartisan action and require this same level of transparency and accountability from the ERISA health plans that are under the exclusive jurisdiction of the Department of Labor. To this end, the APA has endorsed, and is encouraged to see the Committee considering, legislation like H.R. 2874, *The Behavioral Health Coverage Transparency Act* introduced by Rep. Kennedy (D-MA) and H.R. 3165, *The Mental Health Parity Compliance Act* introduced by Reps. Porter (D-CA) and Bilirakis (D-FL), both of which require parity reporting from health plans regarding their medical management practices. While we support both pieces of legislation, we recommend the reporting language in H.R. 3165, because it mirrors the language that many states have enacted to apply to state-regulated plans. With more states expected to pass virtually identical bills throughout the remainder of this year and next, it is important that this uniformity extends to health plans regulated by the Department of Labor.

Telehealth

Swift actions by Congress and the Administration over the past few months have allowed many of our psychiatrists to transition to delivering much of their psychiatric care to their patients via telehealth. The lifting of geographic and site of service restrictions, including allowing the patient to be seen in the home, and the use of audio-only for telehealth when a patient lacks the technology or bandwidth for video, have enabled large numbers of patients, including vulnerable populations to receive care while also remaining compliant with physical distancing requirements that minimize the spread of COVID-19.

Preliminary survey data from almost 600 of our APA physicians shows they and their patients are generally satisfied or happy with the new virtual delivery system and that appointment no-show rates are reduced. The percentage of psychiatrists who reported that all of their patients kept their appointments increased from 9% to 32% from before to after their state declared an emergency due to COVID-19. In conjunction, about 85% of respondents to our survey said that patients who were seen for the first time via telehealth were either somewhat satisfied or satisfied. The decrease in “no shows” and increase in patient satisfaction is consistent with nearly a decade of research on telepsychiatry.

I cannot stress enough how important this is: In general, when patients a) keep their first appointment, they are more likely to keep subsequent appointments, and b) when patients are satisfied with treatment, they are more likely to continue with their course of therapy. Research also suggests that this results in better medication compliance, fewer visits to the emergency department, fewer patient admissions to inpatient units, and fewer subsequent readmissions.

However, we are beginning to worry about what will happen to the current telehealth delivery model once the public health emergency declaration is lifted. Given patients with mental health and SUDs may be at higher risk for COVID-19 due to comorbid health conditions, the satisfaction of both patients and physicians with the delivery of care via telehealth, and the vital need for MH / SUD services beyond the COVID-19 crisis, the APA recommends extending current telehealth waiver authority for at least a year after the end of the public health emergency declaration. We also recommend studying the results of this rapid shift from in-person mental health services to telepsychiatry.

In addition, prior to COVID-19, SUD and co-occurring mental health services were exempt from geographic and site of service restrictions under Medicare. However, the exemption did not extend to coverage focused solely on mental health treatment services. We strongly encourage Congress to make a statutory change to exempt mental health such as H.R. 5201, the *Telemental Health Expansion Act of 2019*, introduced by Reps. Matsui (D-CA) and Johnson (R-OH) which removes geographic restrictions and adds the patient's home as an allowable originating site of service for mental health, legislation that the APA strongly supports. Actions like these would ensure continuity of care for patients who receive their mental health and SUD services via telehealth.

Suicide Prevention & Lifelines

Given the increase in suicides, suicide attempts and calls to SAMHSA's lifeline, especially during the public health emergency, we are pleased to see that today's hearing includes H.R. 4564, the *Suicide Prevention Lifeline Improvement Act of 2019* introduced by Reps. Katko (R-NY), Napolitano (D-CA) and Beyer (D-VA); H.R. 4585, the *Campaign to Prevent Suicide Act*,

introduced by Rep. Beyer (D-VA); H.R. 2599, the *Suicide and Threat Assessment Nationally Dedicated to Universal Prevention Act of 2019* introduced by Rep. Peters (D-CA) and H.R. 1109, the *Mental Health Services for Students Act of 2019,* introduced by Rep. Napolitano (D-CA). The APA strongly supports each of these bills and sees H.R. 4564, H.R. 4585 combined with H.R. 4194, the *National Suicide Hotline Designation Act of 2019*, introduced by Rep. Stewart (R-UT) and previously passed by this subcommittee, as an important package of complementary, suicide-focused improvements to our nation's suicide prevention efforts. Additionally, H.R. 2599 and H.R. 1109 offer improvements to school-based student suicide prevention and mental health programs that are vital for prevention, risk identification and early intervention. As we continue to fight the COVID-19 pandemic and after the virus subsides, we need to ensure that people have access to resources and support to manage mental health and substance use issues, specifically suicide. APA is pleased that the Committee is considering each of these bills, which are good first steps that support suicide prevention and will if passed, save lives.

Emergency Rooms & Crisis Stabilization

In addition to passing these suicide prevention bills, it is important to complement them with a comprehensive, coordinated mental health system to meet varying patient needs, including crisis services to alleviate pressure on overwhelmed emergency rooms. Unfortunately, given the large number of people without adequate access to such services, patients seek services through emergency departments. Given this, our emergency rooms must be equipped to handle suicidal patients or refer them to timely, appropriate care. Emergency rooms with effective suicide screening and identification protocols can improve outcomes and reduce deaths while in these settings and post discharge. As such, the APA supports legislation

that ensures that patients who present in the emergency room with suicidal ideation or having attempted suicide are appropriately screened and referred to the appropriate mental health treatment in order to minimize the potential for post-discharge suicide attempts. Therefore the APA is pleased to see that the committee is considering H.R. 1646, the *HERO Act of 2019*, introduced by Rep. Bera (D-CA); H.R. 2519, the *Improving Mental Health Access from the Emergency Department Act of 2019*, introduced by Rep. Ruiz (D-CA); H.R. 4861, the *Effective Suicide Screening and Assessment in the Emergency Department Act* by Reps. Engel (D-NY) and Bilirakis (R-FL); H.R. 5619, the *Suicide Prevention Act*, introduced by Rep. Stewart (R-UT); and H.R. 7147 and H.R. 7159, introduced by Reps. Bustos (D-IL) and Wild (D-PA) and Rep Latta (R-OH). H.R. 7147 and H.R. 7159 both encourage states to use Community Mental Health Service Block Grant set-aside funding to implement evidence-based crisis care coordination services. Crisis care coordination consists of things like crisis call centers, mobile crisis units and crisis stabilization programs which offer acute or sub-acute care in a hospital or facility for individuals who need specialized support and observation. H.R. 7147 builds upon Rep. Bustos' proposal included in last year's House-passed 2020 Labor-HHS Appropriations bill and is consistent with the Administration's budget proposal for Fiscal Year 2021, both of which the APA supports. Given the strong similarities between the two bills and enthusiasm of the authors, we are optimistic that additional discussions should yield a mutually desirable path forward to support our patients. It is imperative that patients experiencing mental health crisis, overdoses and suicidal ideation or attempts are referred to appropriate mental health treatment and are not left to languish in the emergency room or the judicial system without appropriate referral and follow up care.

H.R. 884 – the Medicare Mental Health Access Act

Psychiatrists and the APA consider psychologists and the American Psychological Association partners in our joint goal to provide patients with the highest quality of mental health care. Psychiatrists and the APA have a tremendous amount of respect for our psychologist colleagues and thank them for playing their important role in the delivery and provision of mental health care. In many practices, psychiatrists and psychologists work together on a team with other providers such as nurses, physicians' assistants, social workers and care managers.

However, we are concerned to see that H.R. 884 the *Medicare Mental Health Access Act* introduced by Rep. Chu (D-CA) is being considered here today by the Committee for a variety of reasons. H.R. 884 adds psychologists to the "physician" definition under the Medicare program. The goal of this legislation is unclear given that Medicare already recognizes and allows psychologists to provide and bill for the services that they are trained to perform under Medicare. Further, psychologists already practice independently in Medicare in appropriate settings. It has come to our attention that our colleagues are advocating in support of this legislation because they feel that the supervision requirements are overly burdensome and serve as impediments to care for inpatient settings.

I need to note that **psychologists are NOT physicians** and simply do not have the necessary medical training to practice and care for patients in the physician role. Additionally, referring to psychologists as physicians confuses patients as to exactly who is caring for them as their physician. Psychiatrist supervision of our psychologist colleagues treating patients with acute mental illness in inpatient and partial hospital settings is essential. Patients in these

settings almost always have comorbid medical conditions, such as hypertension, diabetes and other chronic physical illnesses, that need attention and management by physicians who are trained to treat complex, chronic medical conditions and perform medication management. The Centers for Medicare and Medicaid Services emphasizes that Medicare patients in partial hospitalization programs require "comprehensive, structured, multimodal treatment requiring medical supervision and coordination, provided under an individualized plan of care." At a time when we know that high quality care is best provided by a team of professionals working together to provide coordinated services for patients with chronic illnesses, this legislation would do the opposite of stated intentions and further fragment care by creating unnecessary and dangerous silos between all health care providers who should be working collaboratively.

I would like to stress to the Committee and my psychologist colleagues that if they are looking for ways to reduce paperwork and/or administrative burdens or hurdles, there are other ways to do this that do not inappropriately add their specialty to Medicare's physician definition. I will not belabor this point, but I would encourage the Committee to focus on non-controversial, widely supported mental health legislation that will actually have an impact on increasing access and lowering cost, and promote collaborative models that do not further fragment our already complicated mental health system.

I thank the Committee for choosing to spend today examining several mental health focused bills and policy proposals. In my capacity as APA's President and as a professor of psychiatry training the next generation of physicians, I look forward to working together with you and our colleagues across the mental health community to better our mental health care system and make mental health care accessible for every American. Thank you again for inviting me here

today to discuss the incredibly important issue of mental health. I am happy to answer any questions you may have.