May 21, 2021

The Honorable Chuck Schumer
Senate Majority Leader
322 Hart Senate Office Building
Washington, DC 20510

The Honorable Nancy Pelosi
Speaker of the House
1236 Longworth House Office Building
Washington, DC 20515

The Honorable Mitch McConnell
Senate Minority Leader
317 Russell Senate Office Building
Washington, DC 20510

The Honorable Kevin McCarthy
House Minority Leader
2468 Rayburn House Office Building
Washington, DC 20515

RE**: Mental Health and Infrastructure**

Dear Leader Schumer, Leader McConnell, Speaker Pelosi, and Leader McCarthy:

We, the undersigned mental health and addiction organizations, wish to express our gratitude for Congress' unprecedented investments in mental health, substance use and suicide prevention. These investments – coupled with the enactment of landmark legislation establishing 988 as a universal three-digit behavioral health emergency response number – represent the most significant opportunity to transform behavioral health care since President John F. Kennedy's 1963 call for a "a bold new approach" to mental health care.

To realize the full potential of 988 to transform how our country responds to people in crisis, we urge you to couple Congress' investments in broader mental health services with a **directed investment to build out a national 988 crisis infrastructure of crisis call centers, mobile crisis teams and stabilization services**. This infrastructure is vital to ensure that communities have the necessary services in place for a successful July 2022 roll out of 988.

The Consequences of Crisis

How a community responds to behavioral health emergencies is both a public health issue and a social justice issue.[i] Unfortunately, without a 988 crisis infrastructure, response to mental health crises too frequently falls to systems that are ill equipped to provide necessary care.

Unlike other medical emergencies, behavioral health crises overwhelmingly result in a law enforcement response. Over 20% of total police staff time is spent responding to and transporting people with mental illness,[ii] while more than two million people with serious mental illness are booked into jail each year.[iii] Too often, these law enforcement responses end in trauma and tragedy. Since 2015, nearly one in four fatal police shootings have been of people with mental illness (214 killed in 2020 alone), with one in three being people of color.

The lack of effective crisis response systems also burdens emergency departments (EDs) – facilities that are ill-equipped to address a person in mental health crisis.[iv] One of every eight ED visits in the U.S. is related to a mental health or substance used disorder,[v] but those with mental health conditions to stay 3.2 times longer than others waiting for inpatient care.[vi] Long waits in emergency

departments place enormous strain on individuals, families and staff and result in poor outcomes. The pandemic has worsened this crisis, especially for children and adolescents. From mid-March to October 2020, there was a 24% increase in the proportion of mental health emergency department visits for children ages 5 to 11 and a 31% increase for youth ages 12 to 17 compared to the same period in 2019.[vii]

Core Components of a 988 Crisis System

Fortunately, SAMHSA established a crisis response model to reduce reliance on both law enforcement and emergency departments. It consists of three core components: 24/7 crisis call center hubs, mobile crisis teams, and crisis receiving and stabilization services that provide help when and where people need it.

The data show that crisis call centers hubs, staffed by people well-trained in crisis response, can assist at least 80-90 percent of people calling with a behavioral health crisis without the need for additional interventions. For those who do need more, mobile crisis teams are able to effectively de-escalate a large majority of behavioral health crises and connect the person to follow-up services, including at Certified Community Behavioral Health Clinics (CCBHCs). In situations where the need is more acute, crisis receiving and stabilization services provide a safe, therapeutic setting that reduces reliance on costly emergency department visits and can avoid the need for inpatient hospitalization.

Financing and Workforce Challenges

While there is a clear vision for what a successful 988 crisis response system requires, there are very few examples of systems that meet these standards. Existing suicide prevention call centers rely on a patchwork of inadequate funding, leaving insufficient capacity to meet current needs, let alone the increased demand spurred by the adoption of 988. There is growing availability of mobile crisis teams, but demand still far outstrips supply, particularly for children and adolescents. And there is a nationwide dearth of crisis stabilization programs. Finally, there are widespread shortages of behavioral health professionals to staff crisis response systems.

These challenges are attributable, in large part, to a lack of financing. Medicare and commercial plans cover only very limited services, if any, related to crisis response. Medicaid often covers more for Medicaid-eligible individuals, but still does not begin to reimburse the full costs of call centers, mobile crisis, and crisis stabilization response. Some states are adopting 988 user fees on phone bills, but those fees are minimal and can only support a portion of 988 crisis system costs. Additionally, recent increases to the mental health block grant to improve access to care cannot be used for construction costs of building new crisis receiving centers, call centers, or mobile dispatch centers. As a result, significant investments are needed to develop an infrastructure to successfully stand up an effective 988 crisis response system, especially given the upcoming July 2022 timeline.

Invest $10 Billion in 988 Infrastructure

To establish a minimally effective 988 crisis infrastructure, we urge Congress to include $10 billion in an infrastructure package that includes the following:

- **Technology, training, and operations at local Lifeline call centers** across the country based on SAMHSA's projections (SAMHSA report to Congressional committees forthcoming);
- **Broaden capital projects to include crisis receiving and stabilization and peer respite programs** (HRSA Capital Development Grants);
- **Broaden federal loan repayment program criteria** to include crisis call centers, mobile crisis teams, crisis receiving and stabilization programs, and Certified Community Behavioral Health Clinics as eligible sites (HRSA NHSC Loan Repayment Program); and
- **Expand behavioral health workforce training programs** (HRSA Behavioral Health Workforce Education and Training (BHWET) Program; SAMHSA Minority Fellowship Program (MFP), and HRSA Graduate Psychology Education (GPE) Program).

Because of the vital role Medicare plays as both a payor and influencer of commercial health coverage, it is important to include changes to this mandatory program in an infrastructure package:

- **Provide Medicare and TRICARE coverage of mobile crisis and crisis stabilization services** (S. 5034—Behavioral Health Crisis Services Expansion Act);
- **Provide Medicare coverage of peer support specialists** (H.R. 2767—PEERS Act of 2021); and
- **Extend Medicare's current flexibilities on coverage of behavioral health services furnished via telehealth,** including audio-only services.

Thank you for your leadership in promoting mental health in our nation, particularly as we continue to fight the ongoing behavioral health impacts of the pandemic. Our organizations stand united and ready to work with you to realize the promise of Congress' enactment of 988 to change our nation's response to mental health crises. For questions or responses, please contact Angela Kimball, National Director of Advocacy & Public Policy, NAMI, at akimball@nami.org.

Sincerely,
American Art Therapy Association
American Association for Psychoanalysis in Clinical Social Work
American Association of Suicidology
American Association on Health and Disability
American Dance Therapy Association
American Psychiatric Association
American Psychological Association
Association for Ambulatory Healthcare
Centerstone
Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD)
Depression and Bipolar Support Alliance
The Jewish Federations of North America
The Kennedy Forum
Lakeshore Foundation
Meadows Mental Health Policy Institute
Mental Health America
National Alliance on Mental Illness
National Association of Pediatric Nurse Practitioners

National Association for Behavioral Healthcare
National Association of Peer Supporters
National League for Nursing
Network of Jewish Human Service Agencies
Peg's Foundation
RI International, Inc.
SMART Recovery
Steinberg Institute
The Jed Foundation (JED)
Treatment Advocacy Center
Well Being Trust

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[i] Balfour, M.E., Hahn Stephenson, A., Winsky, J., & Goldman, M.L. (2020). Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies. Alexandria, VA: National Association of State Mental Health Program Directors.
[ii] Road Runners: The Role and Impact of Law Enforcement in Transporting Individuals with Severe Mental Illness. (Treatment Advocacy Center, 2019). https://www.treatmentadvocacycenter.org/road-runners
[iii] Steadman, HJ., PhD, Osher, FC, MD, Clark Robbins, P, BA, et al. Prevalence of Serious Mental Illness Among Jail Inmates. (2009). Psychiatric Services. Volume 60, Number 6.
[iv] SAMHSA National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit
[v] https://www.hcup-us.ahrq.gov/reports/statbriefs/sb227-Emergency-Department-Visit-Trends.pdf
[vi] Nicks, BA & Manthey, DM. (2012). The Impact of Psychiatric Patient Boarding in Emergency Departments. Emergency Med Int. 2012;2012:360308.
[vii] Leeb, TL, PhD, Bitsko, RH, PhD, Radhakrishnan, L, MPH et al. Mental Health-Related Emergency Department Visits Among Children Aged <18 Years During the COVID-19 Pandemic—United States, January 1-October 17, 2020. MMWR Morb Mortal Wkly Rep 2020;69:1675-1680.