

THE BROOKINGS INSTITUTION  
WEBINAR

ADDRESSING THE NATIONAL MENTAL HEALTH  
CRISIS: OPPORTUNITIES AND CHALLENGES

Washington, D.C.  
Wednesday, April 6, 2022

**PARTICIPANTS:**

**Welcome and Introduction:**

RICHARD FRANK  
Senior Fellow and Director  
USC-Brookings Schaeffer Initiative for Health Policy  
The Brookings Institution

**Keynote Remarks:**

SUSAN RICE  
Domestic Policy Advisor  
Biden Administration

DR. DAVID BLUMENTHAL, Moderator  
President  
Commonwealth Fund

**Panel Discussion:**

**Moderator:**

RICHARD FRANK  
Senior Fellow and Director  
USC-Brookings Schaeffer Initiative for Health Policy  
The Brookings Institution

**Panelists:**

KENNA CHIC  
Former President  
Project Lighthouse  
Georgetown University

MARY GILIBERTI  
Chief Public Policy Officer  
Mental Health America

CHRISTEN LINKE YOUNG  
Deputy Assistant to the President for Health and Veterans Affairs

RUTH SHIM  
Luke and Grace Kim Professor in Cultural Psychiatry  
University of California  
Davis School of Medicine

SANDRA WILKNESS  
Senior Program Director  
NASHP

\* \* \* \* \*

ANDERSON COURT REPORTING  
1800 Diagonal Road, Suite 600  
Alexandria, VA 22314  
Phone (703) 519-7180 Fax (703) 519-7190

## P R O C E E D I N G S

MR. FRANK: Hello and welcome. My name is Richard Frank and I direct the USC-Brookings Schaeffer Initiative on health policy. I want to thank you for joining this conversation on mental health proposals advanced by the Biden/Harris administration.

This event is jointly sponsored by the Schaeffer Initiative and the Commonwealth Fund. The program today is consisting of two parts. The first part features remarks from Ambassador Susan Rice, President Biden's domestic policy advisor, who we are pleased to welcome back to Brookings.

Following her remarks, David Blumenthal, President of the Commonwealth Fund will interview Ambassador Rice. That will be followed by a panel discussion of the points made by the President and Ambassador Rice. To get us started, I want to introduce my friend and colleague, Dr. David Blumenthal, President of the Commonwealth Fund who will moderate the first part of the program.

David is a physician that has been active in public policy and medical affairs. He's on the staff on Capitol Hill as a hospital executive and as national coordinator for health information technology under the President Obama. Perhaps most significant for today is David has coauthored a book on health policy and the presidency that is entitled, "The Heart of Power: Health and Politics in the Oval Office." David, thanks for joining us and I'll turn the screen over to you.

MR. BLUMENTHAL: Thank you so much, Richard. It's a pleasure to be here. As a primary care physician married to a child psychiatrist, I've had a front row seat for decades on the failures of our country's mental healthcare system.

There are stories I hear of children failing to get care they desperately need are especially frustrating and heartbreaking. So I'm personally gratified to see the strong commitment of the Biden/Harris administration to taking on our nation's mental health crisis,

which of course began long before COVID.

And I'm also delighted to welcome Ambassador Susan Rice to elaborate on the administration's mental and behavioral health agenda. Ambassador Rice has a long career of public service primarily in international affairs. Most recently as a permanent representative to the United Nations and then national security advisor under President Obama.

Recently, she's turned her considerable skills to the Biden/Harris administration's domestic policy agenda as domestic policy advisor to the President and director of the Domestic Policy Council. Welcome, Ambassador Rice.

MS. RICE: Well, good afternoon, everyone. And thank you so much. Thank you, Dr. Frank. Thank you, Dr. Blumenthal for welcoming me. And I want to say a special thank you to Brookings and the Commonwealth Fund for cohosting this event.

Even virtually, it's good to be back at Brookings. For six years, Brookings was my home for me and my late mother, Louise Rice. And she was there much longer than I. And I really cherish the time that I spent at Brookings, the colleagues whom I continue to consult for guidance. And of course, the comparative good night sleep that you get when you're a senior fellow.

For more than a century, Brookings has prided itself on generating fresh ideas to tackle the myriad challenges facing our society, which is why it is fitting that we're here today to discuss how to address an issue of utmost concern and consequence, our nation's growing mental health crisis. Last December, the New York Times asked 1,320 therapists across the country what they were hearing from their patients.

Certain words jumped out over and over. Anxious, burned out, lonely, empty, dumb. This crisis has long pre-dated COVID. But since the start of the pandemic rates of depression among American adults has tripled. More than one in 10 report thoughts

of suicide. As U.S. Surgeon General, Dr. Vivek Murthy warned in the recent public health advisory, mental health challenges are especially acute among our young people.

In 2019, one in three high school students reported persistent feelings of sadness or hopelessness. A 40 percent increase from a decade earlier. From 2007 to 2018, suicide rates for young people increased 57 percent. With black children nearly twice as likely as white children to die by suicide. As the Surgeon General observed “it would be a great tragedy if we beat back one public health crisis only to allow another to grow in its place.”

Of course, for so many Americans, this crisis is not defined by statistics. It's something that effects a spouse or a parent, a child, a beloved aunt or uncle or cousin, a dear friend. Perhaps it's a challenge we grapple with ourselves. As terrifying and excruciating as these afflictions can be for individuals and families, their impact extends well beyond their human toll.

As President Biden's domestic policy advisor, I have the privilege and the great opportunity of driving the development and implementation of the President's domestic policy agenda in the White House and across the federal government. From healthcare and economic mobility to racial justice and rural policy, from education to Veteran's Affairs. And so, for many of these issues and for so many of our greatest challenges as a society, mental illness is a force multiplier.

Roughly a third of America's homeless population has a serious untreated mental illness. Adults with serious mental health conditions are at least twice as likely to be out of the labor force as those without mental health challenges. As we all know well, prisons and jails have become our nation's largest providers or fail to provide mental healthcare.

In untreated trauma and its associated mental health effects may increase

the risk of involvement in gun violence. There are even national security implications as mental health problems like PTSD and depression among our military service members reduce retention and military readiness.

And yet, despite the magnitude of this crisis, mental health has too often been overlooked and under resourced. At every level our country faces a severe shortage of mental health providers. The providers we do have are often paid less by insurance claims. As a result, half of our most highly trained mental health professionals no longer accept in insurance leaving millions of Americans on the hook for even basic mental healthcare.

These barriers are even greater for black, Hispanic and Asian patients. Add up these obstacles and you can see why less than half of the 52.9 million Americans diagnosed with mental illness actually receive treatment and even fewer receive culturally competent high-quality care.

Recognizing this crisis for what it is, the Biden/Harris administration has moved urgently in our first year to support the mental health needs of Americans. President Biden's historic American Rescue Plan invested nearly 5.5 billion to strengthen mental health and substance use services including the most ever funding for states and communities to address needs on the ground. We devoted another \$122 billion to help schools reopen safely and get students back on track academically and emotionally.

We're making healthcare more affordable and accessible while ensuring that there are more mental health providers and that health plans fully cover those services. We've taken steps to promote safe storage for firearms which are used in more than half of all suicides. And thanks to many of these efforts, schools are hiring more counselors, nurses and social workers. More rural and underserved young Americans have accessed to mental health providers.

More dedicated staff are answering the phones at crisis call centers. More mobile crisis response teams are showing up when someone is in crisis. More certified community behavioral health clinics are providing 24/7 mental healthcare to Americans whether or not they can pay. Lowering costs and improving health outcomes.

But this is just the beginning and it is still not nearly, nearly enough. Many of you have been doing this work for a very long time and have seen encouraging shifts. We've made progress on research, on deinstitutionalizing care, on reducing stigma. But this moment calls for more than incremental progress. It demands transformational change. Part of building a better America is building a healthier America. And mental health is foundational to that goal.

That's why President Biden as part of the unity agenda he unveiled in his State of the Union address called for a major transformation in how the nation understands, accesses and treats mental health. Our strategy is built around three fundamental goals.

First, building a system with enough capacity to treat everyone. Second, connecting people to the services they need by tackling high costs and other barriers. And third, supporting all Americans by creating environments that improve their health and wellbeing in the first place.

To start, we're seeking to partner with Congress to build a mental health system that has the capacity and capabilities to work for everyone. Right now, more than one in three Americans live in areas where the shortage of mental health professionals. In 60 percent of counties in rural America, there's not a single psychiatrist. And when a mental health provider is available, they too often lack the language skills or the other cultural familiarity to adequately serve their patient.

We're working to change all that. The budget President Biden unveiled last week proposed investing more than \$700 million to increase scholarships, loan repayment

and training programs that will bring more and more diverse providers to rural and other underserved communities. And we're not just increasing the number of advanced mental health professionals like psychiatrists or psychologists. We're also proposing a dramatic increase in funding for community health workers, counselors, recovery coaches and others who support to make all the difference.

A few weeks ago, President Biden signed the bipartisan Dr. Lorna Breen Healthcare Provider Protection Act, which invests \$135 million to reduce healthcare worker burnout and care for those who care for us. And in July, we're launching the 988 Crisis Response Line and investing another \$700 million to staff ensure crisis centers and crisis response so that people in need will have someone to call, someone to respond and somewhere to go.

But it's not enough to build a mental health workforce if Americans can't access the help they need. And that's why our second imperative is to ensure that neither cost nor stigma nor red tape prevent people from getting connected to care.

Since the 2008 Mental Health Parity Law, insurance companies are supposed to cover mental healthcare the same as physical healthcare. But too many insurers have skirted those obligations. Accordingly, the President is proposing to acquire all health claims to cover robust behavioral health services including three annual behavioral health visits without cost sharing while ensuring that there are enough in network behavioral health providers.

We requested additional funding to enforce mental health requirements and to finally apply these vital protections to older adults covered by Medicare.

But cost and insurance coverage are not the only barriers to patient seeking care. We must also continue to make it more comfortable and convenient to access care. And that's why we're seeking investments to make sure that mental healthcare is widely

integrated into traditional and nontraditional settings. Whether that's a primary care doctor's office, a college campus, a library or a homeless shelter. And make it easier to find these resources with a click of a button.

We're also doubling down on telehealth and virtual care. Telehealth expanded dramatically during the pandemic and it works especially for Americans without easy access to a provider. We're going to work with Congress to make telehealth available across health plans and across state lines.

Finally, we're looking beyond healthcare settings to foster environments that support and promote mental health and wellbeing. We want to reduce the likelihood that someone develops serious mental health challenges in the first place and help people stay healthy after treatment. Creating healthier environments starts with our youngest clients. That's why the President's budget increases our investment in home visiting programs which give families the skills and support to build safe, healthy homes.

We're also dramatically expanding funding for community schools, which provide essential counseling and other wraparound services to students and their families making it easier for school-based mental health professionals to seek reimbursement for Medicaid.

We're increasing funding for youth focused programs that can help support young people as they transition from school to employment. We're seeking to increase funding for treatment courts which help people recover from substance use rather than get locked up for it. Ensure resources for mental health and substance use disorders in our jails and correctional facilities.

To ensure that help is available in all kinds of settings, we'll also train a range of social and human services professionals in basic mental health skills from housing counselors to the U.S.D.A. employees who support our farmers and ranchers.

And when over 80 percent of young Americans say they use social media daily or almost constantly and one in three teenage girls report that Instagram makes them feel worse about their bodies, we must be equally focused on promoting healthy environments online. As the President has said, we must hold social media platforms accountable for the national experiment they're conducting on our children for profit. To do that, we're working to strengthen children's online privacy and ban ads targeting kids.

We're pushing to institute stronger online protections for our young people and require social media companies to place user safety at the center of their product design. We'll work to stop the discriminatory algorithms that return hateful content when a young woman searches a term like black girls or Latina girls. And we'll invest in research to further understand how social media impacts mental health and how to address it. We owe it to our kids to prevent bullying, shaming, exclusion and self-harm online and off.

Back in February, I had the opportunity to participate in a virtual roundtable with some remarkable black women who have been outspoken about mental health. We had Golden Globe winner actress, Taraji P. Henson, Sloane Stephens the U.S. open champion and WMBA star, Necka Gamakay and Dr. Miriam Delphin Whitman our assistant secretary for mental health and substance use.

These were some of the most accomplished black women on the planet, but they were reminding us that mental health struggles impact each of us. We're all human. We all feel the good, the bad and the ugly. The conversation was moving, inspiring even healing. These powerful women opened up and made themselves vulnerable but as Taraji P. Henson commented after our discussion. Vulnerability is strength. And what's true of individuals is equally true of our institutions and our nation.

By acknowledging our vulnerabilities and identifying our shortcomings, we can grow stronger and healthier. That's what this is about. That's what's at stake. That's

how we will usher in a future where mental health is just considered health.

And with the leadership of President Biden, the support of Congress, those here from Brookings and the Commonwealth Fund and everyone who has been touched by this crisis. I'm confident we can transform how we approach mental health in our country and lift the lives of our fellow Americans. Thank you very much.

MR. BLUMENTHAL: Thank you, Ambassador Rice, for those very comprehensive remarks and the very comprehensive plan that you and the President and the Vice President have advanced.

I have a couple of questions. The first concerns child mental health services. You spoke of the importance of young brains. There are many reasons for the failings of our child mental health capacity. But one of the most important and the one I see firsthand in the volume of demand from my wife's services is our shortage of mental health professionals serving children.

Among the federal policy solutions, you have discussed, which do you see as most promising in trying to balance better the supply and demand for mental health services for children?

MS. RICE: It's a great question. And it really highlights one of the President's key priorities which is building the capacity of our mental health system to deliver quality care where people need it most and especially for kids.

You're absolutely right that a significant driver of our unmet mental health needs is workforce shortages. And as I suggested earlier, over a third of Americans, 115 million Americans live in areas with a shortage of mental health professionals and especially in rural communities and communities of color. So that's why we're pursuing a multipronged strategy to try to address this as part of the challenge.

In the first instance, we proposed a dramatic increase in funding for existing

and new programs that expand the pipeline of behavioral health providers. Investing special attention in building a workforce, a mental health workforce that looks like and is better able to connect with the patients they serve including, in particular, children.

We're seeking to expand the pipeline not only of, as I said, of professional psychiatrists and psychologists but also the community health workers, the peer specialists and others who can provide critical care in community settings. And in particular, in our schools.

In addition to increasing the number of providers, we know we have to improve the capacity of the existing workforce at the same time. And do to that we're proposing action across three different funds. One is, as I mentioned, investing more in virtual care and improving access to telemedicine across state lines.

Another is better integrating the behavioral health services into primary care including pediatric care and ensuring that the primary care doctors have the knowledge and the know how to provide that basic type of service.

And then finally, expanding the Medicare payment system obviously to a broader list of practitioners who draw the primarily beneficial to older Americans and enforcing network adequacy standards to improve the likelihood that one can find a provider that accepts a patient's insurance.

And then lastly, we're trying to advance a cross-agency effort at the Department of Health and Human Services to improve the evidence base behind their efforts and ensure that current and future workforce development efforts are actually informed by timely and comprehensive data.

MR. BLUMENTHAL: Excellent. So another question that builds off your response. Placing healthcare services in communities where the need resides is a proven solution of many of our healthcare problems. And it's been the basis for our very successful

and bipartisanly popular federal qualified health center program. Compared to this program though investments in community mental health services have lagged.

And what do you see as the potential now for community mental health services especially those led by individuals who represent the communities most in need including communities of color and our indignant populations? What do you see as their potential going forward to address our mental and behavioral health needs?

MS. RICE: Well, thanks, David. I'm really glad you asked that question. The President and the Vice President, the entire administration as you know believe that equity and community driven services including care have to be at the center of our efforts.

Our mental health crisis looks different in every community and which it is why it's important that there be tailored solutions. And in addition to adopting some overarching objectives that we actually aim to meet communities where they are and support their own ideas for promoting healing, resilience and wellbeing on a targeted basis on a local level.

And that's why the President's budget request for FY23 proposes a first ever program that will be housed at the Health Resources and Services Administration that will invest in locally driven initiatives that integrate mental health services into the anchors of our community life. Whether they're libraries or post offices or a local community center.

It's especially important to us that these service centers are safe and feel safe to those who will use them. If they're accessible but familiar places and that most likely means that they're going to be operated by people that our local communities know and trust. We also know, David, how important it is to fulfill the intent of the 1963 Community Health Act and increase access to, and the quality of home and community-based care models for mental health.

And foremost, among those models of the community mental health centers

and certified community behavioral health centers, CCBHCs. These centers are comprehensive in their evidenced based sites for delivering both primary and behavioral healthcare, and they work. We know from recent evaluations that CCBHCs lower costs and improve outcomes by making it same day access to care far more available and by improving the integration of physical and behavioral health services.

And last year, SAMSA awarded a record setting \$825 million in grants to strengthen our community mental health centers. Our fiscal '23 budget will go even further if enacted by proposing to permanently extend mandatory funding for community mental health centers as well as for certified community behavioral health centers. Investing nearly \$28 billion over 10 years in making these programs permanent.

And at the same time, we propose to invest \$552 million to expand the number and reach of CCBHCs so that more Americans can access this proven model of care. So these are core elements of the strategy that we've outlined and they are very much integral to the President's fiscal '23 budget request.

MR. BLUMENTHAL: Thank you, Ambassador Rice. Richard, I think it maybe time for us to transfer to the next panel. But if not, I do have another question if time remains? I'll go forward then, Richard. Is that okay?

MR. FRANK: Do you have time for another Ambassador Rice?

MS. RICE: I think our time is close to up, but if there's something quickly I can do, sure.

MR. BLUMENTHAL: I was just going to say that your mention of the primary care setting resonates with me. It's most gratifying to -- some of the most gratifying experiences I had as a primary care physician was when I had a psychiatric or mental health professional close by who I could directly refer my patients to at the time I saw them.

So I'm very interested in and glad to hear that integration of physical and

mental health services at the ground level is part of your agenda. I wonder if you could elaborate on how you see that happening under the Biden/Harris proposals?

MS. RICE: Well, in the first instance obviously it's about, you know, building the numbers of providers who are able to support primary care service providers. It's also giving the primary care providers the tools and the competencies to be able to identify problems in the mental health space and be effective bridges to more sustained mental health access for those who need it.

You know, there are various aspects of our budget request that get to that challenge. And at the same time, you know, a key pillar is really raising awareness more broadly. That these false dichotomies, these artificial distinctions between physical health and mental health are really not sustainable or relevant in the 21st century.

And so, we're trying through a combination of tools. The policies we're pursuing, the financing we're seeking, the way that we're trying to change how Medicaid reimburses. All of these sorts of things are tools that we're trying to utilize to breakdown those barriers and make care more accessible whether in the primary mental healthcare more accessible whether in the primary care context or, as I said, in other community context.

MR. BLUMENTHAL: Right.

MS. RICE: So let me just say to again to Richard and David. Thank you so much for hosting this. Thank you for all your good, hard work. And those of the many who are joining us here today. I know you'll continue to have a very thoughtful conversation going forward. And I look forward to our continued efforts to really make transformational change in this critically important area.

MR. FRANK: Thank you very much, Ambassador Rice. And thank you, David, for getting us off to such a great start.

We'll now turn over to our panel discussion. We have a terrific panel that captures a wide variety of perspectives on mental health policy today. I will briefly introduce the panel members and then pose some questions to them and we will have a discussion around that set of questions. Can you all see the panel? I think we need to get to group mode.

All right. I'm assuming that the panelist can be seen so I will start by introducing them. I'll begin with Christen Linke Young and welcome her back to Brookings. Christen is the Deputy Assistant to the President for Health and Veterans Affairs. And she is on the staff on the Domestic Policy Council.

Next is Kenna Chic who is former president of the Lighthouse Project peer support services. And she had been extensively involved in mental health policy that exceeds for some time. Third on the list is Mary Giliberti who is Chief Public Policy Officer at Mental Health America here in Washington. Ruth Shim is our fourth member and is a psychiatrist and is the Luke and Grace Kim Professor of Cultural Psychiatry at the University of California, Davis. And finally, Sandra Wilkness is a clinical psychologist by training and is currently a Senior Program Director at the National Academy for State Health Policy. So welcome to all of you.

I'm going to send my first question over to Christen to get us going. Our President and the Ambassador just today have described multiple initiatives that extend the existing mental health policies, and others that are quite new. Can you focus on what you see are the important steps that need to be taken to go beyond where policy has been?

MS. YOUNG: Great. Yes. Thank you so much for that question and thanks for hosting us today. It's great to be with everybody.

So you heard a lot from Ambassador Rice about the broad themes of how we are thinking about this moment and the challenges in front of us. There are, I think, two

themes that I really want to underscore as we think about the work ahead. Of course, you've already heard in today's discussion a fair amount of talk about workforce and capacity and the need to strengthen our system's ability to meet need and respond to the clinical needs that people have.

I want to be very clear that the need, our eyes are wide open about the fact that addressing this challenge requires really bold action. We cannot meet the moment and address the challenges that we face today by tinkering around the edges of the programs and systems and services that we have in place today. We need bold and transformational changes in the way we think about our workforce and we think about the system's capacity.

So that includes really meaningful new investment in our clinical workforce and programs that support our clinical workforce. You saw a pretty significant investment in the President's FY23 budget that are focused on that sort of clinical investment and a different scale and a different magnitude that we've seen in this space before.

We also need to be moving quickly to empower peer support resources and other types of paraprofessionals. This is not a problem of clinicians alone, but one where we need to think broadly and flexibly about what the workforce of the future is to meet demand. And we also need broad and creative thinking about how we bolster community capacity and keep building on the progress we've made in recent decades to move and more resources into communities.

So again, I think the President's budget lays out a framework for thinking about the scale of the investments that we need. And I want to sort of underscore that that scale is really what we see in the moment as requiring.

Secondly, I just want to say a little bit more about mental health parity and sort of the path we see from here. The Mental Health Parity and Addiction Equity Act has been a powerful bipartisan tool signed into law by George W. Bush that has made a really

solid foundation for seeing progress in getting more Americans access to insurance coverage for behavioral health services.

We think there is more we can do as the federal government to set clear standards and to enforce the law. And we're committed to doing everything in our power to maximizing the parity framework and driving improvements that we can. At the same time, I think we recognize that there are ultimately limits to how far our parity analysis can go and there are limits to what we can do within the framework of the existing law.

And if we want to ensure that across our healthcare system an insurance card actually provides meaningful access to the mental health services that people need, we need to move beyond a sort of strictly parity-based analysis. And that's why the President's budget calls for requirements that all insurance plans, public and private, cover a robust set of behavioral health services, network advocacy requirements attached and sort of really it raises the bar on what it means to provide adequate mental health coverage.

So I'll just say a lot more in the conversation, but those are two themes that I would really watch that.

MR. FRANK: Thanks so much, Christen. That is a very great way of getting us going. Ruth, Christen has highlighted a multiple pronged approach to expanding the mental health workforce capacity.

You're in the business of training clinicians. What do we need to put in place to make sure that the expanded workforce is prepared to equitably help all Americans?

MS. SHIM: So thank you so much for that question, Richard. And I do think that expanding the workforce is a really exciting prospect. And it's a massive undertaking kind of as Christen discussed.

As a psychiatrist, I want to speak briefly to my personal experiences in

training medical students and psychiatry residents. And as it stands, the pathway to become a mental health provider in this country is really quite challenging. And it often excluded talented and diverse people who have a desire to serve their communities.

And we see actually that interest into going into psychiatry is at an all-time high. It's actually one of the most competitive specialties in medicine, but within medicine it's still extremely challenging for people from diverse backgrounds to successfully navigate the many structural barriers that are in place to become a psychiatrist.

And when I talk about people with diverse backgrounds, I'm talking about people with disabilities including people that have serious mental health problems themselves. People from lower social economic status or people from disadvantaged backgrounds. And people that are minoritized or marginalized in society.

And so, all of these things. It's extremely challenging for these populations to kind of deal with all of the challenges that it takes to become a psychiatrist, to become a psychologist. These are massive structural barriers that we have to think about addressing as we're moving forward.

But similarly, there is this huge demand for paraprofessionals and those that are interested in paraprofessional education. And there are, again, many available slots. And there are more people that are interested in these positions than there are slots for those people in schools and training programs.

So the focus on the expansion needs to be coupled with ongoing support of providers to work specifically in the public sector. So as Ambassador Rice talked about, a lot of psychologists, psychiatrists, paraprofessionals, they opt out of working in the public sector system in favor of private practices, in favor of cash-based setups, which doesn't really meet the majority of people who seek mental health services in this country. It doesn't meet the needs of those people.

And then finally, related to workforce and equity, I think one of the most important issues around equity is appropriate representation and inclusion. And so, that's where peer specialists become a critical part of expanding the workforce because there are our best chance to ensure that people will serve the communities that they come from and that they will provide services in these very communities that have the highest need.

So the potential to expand care and create greater access to care is fully dependent on expanding and fully resourcing a peer workforce that can appropriately build, that can appropriately provide these services. And it also will us to expand into the environments where we are delivering services like schools, churches, workplaces and other community spaces that don't traditionally -- where we don't traditionally access healthcare settings like clinics and hospitals.

MR. FRANK: Thanks. Kenna, I'd like to sort of jump over to you. Now, for those of us who have been around the mental health field for some time, it is a remarkable development when the President of the United States in the State of Union proposes an initiative that features peers as a key component to addressing the mental health workforce challenges and access to care. What needs to happen to ensure that the field avails itself to this opportunity?

MS. CHIC: Good question. Thank you so much, Richard. And thank you to Brookings for highlighting this important topic. It is such an honor to be on this panel with such distinguished leaders in the behavioral health space.

So firstly, I do want to start off and affirm what you said, Richard, which is it is such a historic event for us to have the President highlight peers as a key component in an initiative. In the last two decades, peer support has gone from a practice to a robust advent space service.

Christen and Ruth have done a wonderful job of highlighting the importance

of peer support and I wanted to expand on that. Namely, to highlight that peer support is important too. Not just the client receiving behavioral health services, but the peer, the provider and the overall mental health delivery system.

The client receives social support and experiential knowledge and care by simply interacting with and seeing people who have gone through that journey of recovery, which is so powerful. And peers also bridge the gap between clients and providers to build trust. Peer supporters themselves can also find support within more difficult experiences and really maintain their own wellness by utilizing their insights to support someone who is experiencing a similar behavioral health struggle.

And finally, peers are beneficial to the mental health delivery system itself through decreasing hospitalizations and crisis. Obviously, any transition on this scale will be difficult and there are certain complexities that need to be addressed when integrating peers into the workforce. For example, we would have to think through the existing peer workforce and what standardized certification moving forward would mean for them.

We would also have to discuss other items such as the wages that peer specialists receive and their career trajectories or lack of career mobility in some cases. And also finally, the role of peers within the rest of the care team. I do think that creating an approach that addresses these complexities at the onset will ensure successful implementation of peer support in the future.

And lastly, I will say that in the last decade or so, these stigma against mental health and wellness has improved as opposed to previous years. And it is important to recognize that while the PSA of it's okay to get help is still very relevant and important especially for historically marginalized communities. We also need to recognize this message that help, culturally responsive and consensual help needs to exist when people ask for it.

Peers play a role in expanding the workforce and increasing culturally responsive care and exponential learning which is vital to addressing the great need in our society.

MR. FRANK: Thanks, Kenna. I'm going to shift over to the other part of Christen's comments by asking Mary, you worked in enacting parity. You worked on implementing parity and making it effective.

The Biden administration is sending out the view that they will, on one hand, work to promote stronger enforcement measures while also taking steps to address incentives and structures that are harder to reach with the parity legislation. Do you have some advice on where to concentrate those efforts?

MS. GILIBERTI: Yes, definitely, Richard. When I think about the trajectory in parity, I think a little bit about playing chess with my brother. Where I think I'm winning. I'm winning some pawns and then he makes a move and I know I have lost the game. And every time my family and my friends ask me to find an in-network provider for them, I realize that we're still losing the game.

So what are the three areas of winning moves that I would focus on? First, I talk about network performance. And Christen mentioned network advocacy standards. I think the administration is right to tighten those. You're hearing the insurers are ready, kind of squealing about it. So you know, you're moving in the right direction, but focus on the performance. So these ghost networks, you know, everyone of us has probably done this.

You call down the list and they're not really providing services. We should do better. We should audit those directories. We should make sure that claims have been paid in the last six months. And if not, they don't belong in that directory because they shouldn't be part of the network that gets counted. Similarly, wait lists, things like that. Are they taking new patients? How is the network performing for the person who is trying to get

the care?

The second area that was touched upon was getting the services. And the administration is working to ensure that behavioral health services are provided by all plans. The ones having to focus on that have a parity analysis is crisis care. So we pay for crisis when it's a physical crisis, but we don't always pay on the mental health side particularly in private insurance and Medicare. And Medicare needs modernization for mental health, right? We just did an act.

So the parity piece is important in Medicare. Covering peers, we talked about peers, but they're not covered in Medicare and that needs to change. And in addition, Medicare needs to cover price of services. So looking at those service packages.

And then finally, following the money. The administration is making some changes on cost sharing. I think that's really positive including an integrated care and then in provider reimbursement. We know the market is failing. Anybody who has looked at how high out of network coverage is, and Ambassador Rice mentioned this, it's sky high. The market is failing.

So what do you do when the market fails? You have to look at why? And the rates make no sense. And so, I think that could be a parity analysis, but there are tools in Medicaid. You know, we're talking about peers. That should not be a poverty profession, which it is now in Medicaid. Let's just acknowledge that.

So those tools in Medicaid need to be used. And in Medicare, we're using standards that are promulgated by medical professionals. Not always the best to judge mental health and the demand there. So where there's market failure, we need to start looking at rates and using all the tools that we have.

MR. FRANK: So what we've done here is this is a somewhat historic pivot from sort of parity in law to parity in principle, which is sort of where Christen has taken us.

Christen, do you have any further thoughts on these observations?

MS. YOUNG: I agree with all of what has been said and appreciate all the tremendous thinking going on, you know, across the country to bolster this work and help us focus our efforts.

Maybe one piece that I would add here is just I think it is critically important that we be mindful of building an evidence base as we go into all of this work. As we think about innovations in care delivery, and innovation in workforce. We need to be mindful of building the evidence base that led to us. Like scale innovation quickly and know what is working so we can bring it to communities quickly.

And then similarly, on the parity side. I think it's really important that we hold ourselves accountable for like robust evaluation of what we're doing and what's working and how we can help healthcare resource going forward.

MR. FRANK: Right. Thanks. I'm going to move to a slightly different angle on these issues by asking Sandra a question.

You know, so much of what has been spoken about today and what also appears in the President's budget depends on state government activity and initiatives. How are states taking up the federal priority challenges that Christen and Ambassador Rice have highlighted today particularly on the workforce for community-based mental health care? And also, on expanded efforts to sort of go on beyond parity, if you will? And also, what does this all mean for a set of new versions of the federal, state partnership in mental health?

MS. WILKNESS: Yeah, Richard. Thank you so much for the question. I think your audience is going to hear a lot of the same themes which I think is very encouraging with respect to the federal and state alignment around these efforts.

And, you know, as many have noted the crux of this is really workforce with

respect to building system capacity and that's been known among state officials doing this work for quite a long time. And it's just the challenge giving how ubiquitous the workforce shortages continue to be. But I just want to highlight a few efforts I think on the state side that will demonstrate that they're working to move the needle. And that these new investments and new partnerships can really hopefully expedite some of that effort.

A lot of these are really focused on marrying workforce approaches with best practices. Practices in thinking about team-based approaches and cross sector approaches. States are leading in developing payment delivery models that support effective integration of primary care. We've heard about that. But also conversely, bring primary care and other evidence-based of practices into mental health centers through certified community and mental health center model and other models.

So it's really trying to tackle both at the same time because, you know, many people especially those with more complex needs enter the system through mental health and not through their primary care provider.

Also, building on early lessons learned. There's some early adopter states in building out crisis service continuum. We've talked about that. And really the need for that there to help people leave acute care settings, institutional settings if the care is not appropriate for them there and really build out a robust continuum on the community side.

With respect to the lived experience and community-based workforce, there are a number of efforts underway to work closely with that workforce in partnership to develop career pathways not only for peer support specialists and community health workers and recovery coaches, but really thinking about starting to think about -- we have some space to really starting to think about those as a network of providers rather than providers rather than individual parts.

How do we bring everyone together in really this sort of comprehensive

approach to strongly use of community? The only thing I highlight with respect to diversifying the workforce, others have commented here is there are a number of really interesting models in play with uncommon partnerships to build the pipelines reaching all the way down to middle floor and really thinking about bringing people who are representative community into the behavioral health workforce.

And then, of course, we've talked already about teleconsultation and telehealth. And to Christen's part, really thinking about building a learning health system around those kinds of interventions to look for the best possible way to touch as many people as possible in a culturally informed way and also deeply where needed.

And I would just say all of this is really requires a cross sector and holistic approach. I think a couple of workforces that we haven't talked about that are really compelling on the behavioral health side is thinking about how the traditional behavioral health workforce and now more community-based with experience connect with workforce to provide housing support, employment support, the education workforce that we know are all key players and really these more holistic efforts to offer services to people where they are.

On the state side, what this means is successful cross agency in our governmental alignment of policy, investment and outcome measures. There seems to be real opportunity to partner with the federal government to mirror that on the federal level as well. So I'll just give an example. The interagency work on health and housing with CMS and SAMSA and HUD and the Administration for Children and Families all working collectively to figure out how do we really (inaudible) these resources in support states and locals in offering these services. Happening on the state level as well. And there's real opportunity for a partnership.

My last comment because I could talk forever about this issue is that success, of course, also hinges on bringing the commercial and private markets to help build

that capacity in the community and drive access to quality care, which ultimately reduces stigma and false stigma that interferes with access to care.

We've already heard from Ambassador Rice insisting very clearly about this need. We have a long way to go. On the state side, there are a number of states that have enacted parity laws that I think can be built upon.

And while states are working also in partnering an enforcement of parity through insurance commissioners and other. This type of oversight is really resource intensive in that federal/state partnership can go along way to expedite in those efforts. And with that I'll turn it back to you, Richard.

MR. FRANK: Thanks so much. That was a very rich answer. Ruth, going back to the question of fairness and equity, if you will.

President Biden has raised several issues in the plan. The touch on equity and justice that meant to us fair. You've written extensively on these issues. Can you comment on what needs to happen to these ideas to truly put us on what you've termed the path to mental health equity?

MS. SHIM: Yes. Thank you, Richard. I am really pleased that at the administration is focusing on equity and justice. And I think that one of the biggest challenges and threats to equity is the fact that there is inherent social justice that was really built into the system.

So we have to acknowledge that our healthcare system was designed to benefit some and disadvantage others. And then when we expand that to the mental healthcare system, it's even more readily apparent that these systems were designed without significant input or feedback from the people that were most in need of support from the system.

And so, that social injustice is really kind of a foundation. It's why we see

criminalization of people with mental health and substance use disorders. It's really one of the reasons why our safety net is kind of a last resort and that many people end up in this kind of last resort system.

So if we have this desire to move towards equity and justice, it's critical that we consider and challenge the fundamental ideas that we have about people with substance use disorders and people with mental health problems. So we call these things the social norms that we have around who is worthy of disadvantage and who is worthy of advantage in our society. And the decisions that we make as a society about those things.

And so, we really have to think about reforms that center the voices of those people who've been consistently excluded from power. And this is one of the reasons why we've seen the consumer movement become so important in thinking about our mental health system. It was born out of necessity. It was a need for consumers to have to advocate for their own needs that weren't adequately being met.

So if we're going to move forward and implement these really bold initiatives that I'm so pleased that we're moving towards. We have to ensure that the voices and needs of our consumers, people with lived experience and people that are on the ground in their communities are elevated and incorporated into any policy that we design.

Just a very quick example of this relates to telemedicine. So we're talking about all these incredible telehealth opportunities in mental health. And they're wonderful, but we have to kind of simultaneously think about the equity issues. And the fact that a significant number of people in this country do not have access to broadband. Do not have access to internet. Don't have access to kind of a secure private location by which they could have a telehealth appointment or session. And so, we have to take those types of things into consideration as we're designing these policies.

And then finally, the most -- one additional important issue around equity

and justice is the fact that we have a very reactionary mental healthcare system right now. So we're really focused on treating people after they've experienced challenges. But we know that the majority of our chronic mental health conditions develop and present in childhood or young adulthood.

And so, we really have to shift to promoting mental wellness. I very much appreciate that Ambassador Rice discussing the importance of targeting algorithms that share discriminatory and harmful content to impressionable young minds and particularly women.

I think we have to expand that work to protect against discrimination against transgender youth and other marginalized youth. And we have to use the evidence and data that exists to ensure that we're building self-esteem and identity of our youth and promoting mental health rather than inflicting trauma on young people.

MR. FRANK: Thank you. Staying a little bit with this theme. Mary, I wanted to kind of come back to you. And you've been somebody that has spent their career championing an economy for people with mental illness and community-based delivery.

Now, as you think about the key hurdles about sort of meeting the moment as outlined by Ambassador Rice and the President and Christen. What do we need to do to sort of get over those hurdles? And how should people within the mental health system support those efforts of sort of pushing the improvement agenda, if you will?

MS. GILIBERTI: Well, Richard, I think that those of us who spent a lot of time advocating for mental health services don't always want to acknowledge that sometimes those services don't provide that autonomy you mentioned. Sometimes, they're traumatizing. They treat people without dignity and without regard to their choices.

And so, it's really important to think about that and integrate it into what we're doing in both what Ruth talked about is having people with lived experience in the

planning. In hearing from them in a broad way.

And we're talking a lot to Congress and the administration, how are we getting those voices elevated of people who can speak to this. But then as you said, (inaudible) in civil rights. How do we look at structural discrimination and talk a lot about stigma? But I'm more concerned about structural discrimination. And then patient experience that's where we see it.

So in the healthcare system, right, we do surveys of patients and even in Medicare we pay based on that. You go into a general hospital, you're going to get that survey. There's only one group of patients that is excluded from that survey. And it won't be any surprise to anybody on this panel, it's people with mental health conditions.

Psychiatry facilities, they don't even have to collect the data, never mind be paid on it. We are building a whole crisis system through 988 from the ground up. What patient experience data are we going to collect? How are we going to make sure it's equitable going to Ruth's point? How are we going to know who got served by behavioral health and who got fleeced involvement?

How are we going to know the answer to those questions? What data are we going to gather in how people are treated? You can't just say, well, it's crisis care so it's going to be good care, no. You have to collect the patient experience data. And we should pay on it because that's what's going to get people's attention. But what happened with those hospital surveys is nobody tested on people with mental health conditions.

They didn't even start by testing it on them. So we're creating a crisis system. We're creating new services every day and paying for them. We're talking about paying more. We should be asking for patient experience. How is it experienced by people? And we should pay based on that too.

MR. FRANK: Thanks. Interesting always to hear you speak as an

economist.

So, Sandra, you know, as we think about getting these things really on the ground. We live in a big diverse country with big differences in their mental health systems. Do we have a sort of broad enough spectrum of evidence-based approaches to pursue the key elements that we're talking about here in the President's plan? And, you know, how are they going to fit in, in terms of essentially matching states with where they are and where they need to be?

MS. WILKNESS: Yes. Thank you. That's such an important question. And I want to go back and reiterate. I think the focus here on really developing a learning health system approach as we bridge what we have all been talking about which is the access to quality care chasm here with behavioral health.

I think that's really important so I want to emphasize that there's much more to still be developed. Having said that we do know in a lot of places what works. For example, we can be investing in those innovative approaches we were talking about, building out the crisis continuum, comprehensive mental health school effort and really working to really weave in the lived experience workforce into the fabric of our responses.

So we do know what works and we can start to build on that now. And also stop focusing on what doesn't work at the same time which I think is a really important counterpoint. I would say again it's important to note that some of the most powerful and impactful interventions and especially those with more complex behavioral health needs are really those full person interventions. We have a lot of evidence for those interventions as well.

Safe and affordable housing, gainful employment, meaningful social connections. And for our children and youth, it's those links to school. So the school serving as a mental health hub and clear connection to systems of care and support in the

community. And models like those developed in concert with the gain center.

We've touched a little bit already but there's a lot of practice around all the points of intercept with the criminal justice system to not only help people not ever enter that system but to leave that system at various points. So we do have a lot of information about what works. These can be tailored to communities and a variety of state and local leaders, across the geopolitical and geographic spectrum are advancing those approaches in really unique ways in communities with various champions that aren't always people who are trained in behavioral health as the leads.

So looking forward to the federal leadership to help continue to build that and the President's commitment to this community led mental health resource effort from the ground up I think is going to be really key. So I guess the short answer is we need to keep growing. There is a moment here to really take advantage of what you already know and get creative around tailoring those needs to meet the needs of those communities they're trying for.

MR. FRANK: What I was hoping to do actually. All of these comments have raised sort of a question that the mental health system has not been very good at. And I just wanted to just throw this question out to anybody who wants to take it.

Which is, you know, the model has been people, mental health professionals, sitting in their offices and wait for people to knock on the door and raise their hands to get care. And really what all of you are talking about is really a sort of more of an outreach and a targeted outreach approach. And that began with Ambassador Rice's comments about sort of touching people in libraries and shelters and things like that.

How are we going to get there? How do we build a system that starts to really do outreach in a smart targeted kind of way? Anybody who wants to take that one, please do.

MS. YOUNG: I'm happy to start. So I think two thoughts are coming to mind. The first is we have been thinking a lot about mental health as of kids. I think COVID has, you know, really exacerbated the mental health crisis for children but there's longstanding issues there.

And when you think about the needs of our young people, they are needs that are going to be met by placing professionals in schools and meeting kids where they are. And, you know, the model care delivery as we think about expanding the services that are available to kids is one that I think very naturally lends itself to this more sort of outreach focused approach.

And so, I think there's a lot we can learn about how that works that I hope we'll be able to generalize to the rest of the system. And I think we can see improvements there.

The other point I would make is, you know, another place that we have been thinking about to get better investments is just how we build an entire social safety net that has, you know, is able to deliver trauma informed services and is cognizant of mental health first aid and just sort of basic -- how we take our whole safety net and we make it better for people who are in crisis or otherwise have mental health needs.

And again, I think sort of creating more of those access points that are rooted in people whose jobs are not being a behavioral health professional can provide a much more sort of maximum access that you're talking about, Richard.

MS. GILBERTI: And, Richard, I'll just add -- I'm sorry. I just want to add on the payment side too. You know, some of those outreach services always wind up being grant funded. And we need to be thinking about how to better incentivize those kinds of programs. And I think about things like a sort of community treatment, which is very much an outreach service, but it's so hard to bill for it.

You've got to breakout all this stuff. What you can cover, what you can't early emphasis in psychosis programs are like that too. A lot of their programs, we make it hard to pay for the things that are good. And so, we've got to switch that up and change that whole mentality. Same thing with school-based services that Christen was talking about. You know, how do we make it easy for Medicaid to pay for those?

You know, bouncing the different definitions of the educational system, with the healthcare system. It's really difficult. So integrated care, we don't have the startup costs covered. And it's not enough reimbursement. So I really think the big thing is to think about what do you want? And how do you make sure you make it easy to pay for and adequately paid for for the things that you do want to see like outreach?

And peers do a lot of that outreach which goes back to funding them among private insurance, Medicare and Medicaid.

MR. FRANK: Anybody else?

MS. WILKNESS: The only other thing I would add to that and certainly underscore everything that (inaudible) said is that as we do this and we start to normalize behavioral health as part of healthcare at large or mental health, overall mental health and wellness. You know, bringing the head back to the body as it were.

As we do that there will be more opportunity for folks to engage in the outreach efforts that are underway and I think there will be more points of access as we go forward.

MR. FRANK: Okay. Anybody else? No? All right. You know, actually going back to the question of youth that Christen just raised. Kenna, the President has put a special focus on issues related to the mental problems of youth.

And, you know, Christen just sort of reemphasized that point a moment ago. You've committed a great deal of the effort in your work to attending to mental illnesses in

youth and young adults. How does the initiative focus on schools and early childhood and suicide? How is that going to alter the landscape for providing sort of timely interventions for young people?

MS. CHIC: Good question, Richard. I think firstly to ground our understanding of the situation and exactly how dire it is as Ambassador Rice had already mentioned. We do know that even before COVID, a third of high school students reported feelings of sadness and hopelessness.

We also know that since COVID, we've had suicide attempts in emergency rooms where it is over 51 percent amongst adolescent girls during the pandemic. And so, two of the proposals from the Biden/Harris administration that I really want to highlight in my response is firstly the proposal to expand early childhood and school-based intervention services and supports in the FY23 budget to give \$70 million to youth mental health services including infant and early childhood mental health programs.

We've known and alluded to this throughout our panel, but half of mental health problems begin before the age of 14. In our society, we don't talk about mental health and there seems to be an expectation that has people grow older, they magically learn how to take care of their mental health and emotionally regulate themselves. Unfortunately, that is not the case all the time.

So it is so important to guide young children through social/emotional cognitive and behavioral health development such as through good behavior games tried and tested in Baltimore which will really create a world where when these youths become adolescents, they will at least be aware of mental wellbeing and be familiar with professional resources that can support them during difficult times.

Be aware or resilience skills. And also, healthy coping mechanism which are unfortunately not topics that we generally touch upon within schools.

The second topic that I wanted to mention in the Biden/Harris proposal is also expanding access to mental health support in schools and colleges and universities. This is a billion dollars to help schools hire additional counselors and school psychologists. And I really believe the effort to enhance focus to schools as Christen previously alluded to is so helpful because it makes mental health accessible. It brings care to where the students are.

Many students may not have the time or the education about mental health or the transportation or the money to seek resources on their own. This especially hits historically marginalized communities very hard especially in immigrant communities where there maybe shame associated with struggling because how can you struggle when your parents were refugees and had seen so many atrocities and you haven't?

And so, there are these intricacies as we talk about our behavioral health system that we generally have not touched upon. And I think it is so important at least to have that baseline access for young people.

So many people try to navigate the behavioral health systems for the first time when they are in crisis. And this is because we don't really talk about when is a good time to seek mental health services. And so, what ends up happening is that as people are going through crisis, they are also dealing with bureaucracy and long wait times and insurance and lack of culturally competent care and other factors that really make it even more difficult for people to receive the support that they need and it ends up, you know, crisis situations escalating and tragedies. And so, I do believe that timely intervention and early access can support and save lives.

The last piece I do want to say is that if we want to save lives, we need to create a world that people want to live in and this is a world that prioritizes individuals and community flourishing which starts with focusing prevention and suicide for our youth.

MR. FRANK: Thank you. That was great. Christen, do you want to jump in here and follow up? Or I have some questions coming in from the audience.

MS. YOUNG: Let's go the audience questions.

MR. FRANK: Okay. So one important theme that has been raised by the audience is this sort of tension between the desire to sort of go upstream and focus on preventions on one hand, but the sort of shaky evidence that we have on a late of ideas about, you know, we don't have really strong areas of prevention outside of the few.

And some of those are in the Biden plan such as the home visiting program, the early childhood things and some of the emphasis that Kenna just discussed on youth. But the question is, you know, are we going to be able to make investments beyond that? Learn beyond that? And again, reactions from anybody. Maybe we start with you Christen if you have one?

MS. YOUNG: Yeah, sure. So you highlighted the first place (inaudible) went which was the importance of our youngest minds. And the fair amount of pretty good evidence we have that interventions there can move the needle and need to be scaled up. So if you think about sort of where to spend your marginal dollar investing in these proven programs that do a great deal for young people is a good place to start.

I also think there's reason to be optimist about our ability to develop the evidence-based here. This has been an under resourced of research over the, you know, the last decade or so. And so, with not huge dollars we have the opportunity to -- so I think really move the needle and fill with evidence-based that doesn't take, you know, decades to develop.

You know, I think a lot of these things have -- you know, we have the opportunity to build evidence in ways that it is actionable for us.

MS. SHIM: And if I could just make a comment. I think that -- I actually

don't think that the evidence is that shaky around preventative efforts. I think we have some really powerful evidence that shows that very minimal interventions can have huge sweeping protective impacts.

So Kenna mentioned the good behavior game which has incredible data in terms of a number of outcomes in adulthood past your, you know, age 40 in terms of incarceration rates and general overall wellness. That this tiny little intervention that doesn't require a lot of money can lead to a significant amount of mental wellness throughout a lifetime.

And so, what I get stuck on is then how is this not a universal intervention in every single school in this country? Especially because it is not expensive. And so, we have the same data around early childhood education programs. We have lots of data to support interventions. And so, it's really just a matter of getting over this barrier of taking the evidence that we know is really effective and actually applying it in some sort of kind of consistent and systematic way.

MR. FRANK: Yeah. I think what the questioner was raising was I think they accepted the fact that there is pretty good evidence on early childhood and youth. The issue is that there's a lot of mental illness that happens after.

And the question is do we have interventions there? And, you know, I think that's an important one. And what's interesting is Tom Ensol (phonetic) who used to direct the NIMH recently put out a book. And one of the sort of points that he raised is that we sort of -- and this is building on Christen's observations that we've put our money into the wrong places on research in some sense. That we haven't put money in the places where it leads most directly to interventions that can actually help.

And I was just wondering whether anybody in this same sort of stream of discussion wanted to comment on that? You're shaking your head, Ruth. So you look like

you're ready.

MS. SHIM: I have a lot of passionate thoughts about this because I absolutely feel that the research funding and the research dollars -- and I've had these conversations at MNIH with Dr. Gordon at length.

I feel that the money that we spend around research interventions gets very, very specific to specific illnesses, specific conditions. And I think actually the entire structure of kind of our funding is, I think, a little bit not design to effectively lead to innovative improvements.

So, you know, rather than -- so that gets to a conversation that's probably much longer than we need to have here today. But around kind of the structure of academic medicine and the research enterprise and how we actually have to kind of address the structural racism that's going to build into the research enterprise.

But also, the idea that back to this model. There are communities. There are people on the ground that are really effectively doing this work. And what they're needing to do it on a larger scale or to scale it up is really just resources. And so, a lot of the research funding that we're putting into trying to find like a gene to make intervention on a particular illness or to cure a particular mental health condition, we could actually I think divert that money towards social determinance and give that money to the upstream causes of, say, unemployment or things that relate to food insecurity or things that relate to poverty.

And that would, I believe make a much huger impact on mental health outcomes than looking for a specific gene. But I have strong opinions about this and I don't - I recognize there are other perspectives.

MS. WILKNESS: Please, go ahead, Mary.

MS. GILIBERTI: I just wanted to add that another agency that MNIH has been working with is the CEC because if you're going to go upstream, you go to public

health. And there is a role for public health to be looking at mental health.

They do it in many other conditions. They do it in substance use, but they're starting to do more work in mental health. But there's a long way to continue to go in partnership. So I would just add that piece of it as well. Thinking about how we can create a public health, mental health agenda going forward.

And that gets to some of the research that CDC does and some of the programs and data collection and other public health work. So I just want to point out that that's another prevention strategy that we've been working on and fully support. And, you know, want to see going forward.

And the President's budget also just -- that has a prevention set aside in the lock grant to start looking at moving upstream for a portion of the resources. And we think that's the right direction to be moving.

MS. WILKNESS: Richard, if I may offer just a real quick thought here on translating. You know, if you have a solid evidence base translating that into actual practice and implementation. There's going to be another layer of actually being able to invest in capacity to offer those services.

And that's where you get into the policy, financing landscape and some of the challenges that have been highlighted before. The real need to brave resources on state, local levels. To bring in players who operate locally on the state or the federal level and not necessarily all in the same ballpark.

And really doing that across agency, intergovernmental work is key to actually implementing. And can take many, many years off of, you know, our challenge here if we can do that effectively at all levels of government. So I'm really encouraged by that opportunity.

MS. CHIC: And finally, I had a point. Just to emphasize on what Ruth

talked about in terms of cultural competency and equity in the research place.

The question for me is how many people of color are performing these researches and are included in these research studies because there is a reason why, for example, eating disorders are consider the disorder that is mostly just for white women who are middle class.

And so, there are different determinants of how people are impacted by these systems. But the answers that we get from researchers are often times driven by who is performing the research and who was involved in the research? So I think that is also a very important piece to address if we're going to be talking about equity and behavioral health.

MR. FRANK: Thank you. Staying on the related theme. A question has come up that basically asks -- and this is my translation of the question, which is essentially how important is it to provide training and care for parents particularly of young children in terms of promoting their mental health and mental wellbeing?

And I think the author of this question was essentially alluding to the body of research that shows that, for example, parents with depression tend to have a harder time fulfilling their parental role. And actually, gets transmitted into generationally to their children in forms of behavioral issues. And that has benefit design consequences. It has to do with how you pay for pediatric visits. You know, do you screen the mother in the pediatric? Are there any comments on that? Sandra, you look like you're ready on that one.

MS. WILKNESS: Yeah. I'm happy to jump in. There with models like Healthy Steps and things like that. And it maybe a really good model I visited at (inaudible) at one point where there was an opportunity to offer interventions for the child, but also for the parents. And really understand what the parents' needs are as well.

So I think I'm just strongly endorsing that is an approach to take. And

certainly, we know very well from adverse childhood experiences literature that there's a real need to intervene in the caregiver level. And that there are opportunities to really change the trajectory in very dramatic ways around health and wellness and being able to help for kids there.

MR. FRANK: Is there anybody else?

MS. SHIM: Just to add on to what Sandra was saying. I think, you know, the nurse/family partnerships are a really good example, again, of kind of focusing on the mother and the benefits improve for the mother but they also improve the infant and throughout their lifetime as well.

So again, another really effective, pretty low-cost preventative intervention that really does highlight the importance of paying attention to families and supporting families.

MR. FRANK: Yeah. And it also, I guess points to sort of pediatric practices as being a potential hub of integration and prevention.

MS. SHIM: And also, kind of highlighting the role of the nurse and elevating the importance of nursing, which again when we think about the mental health workforce, we're not always including nurses and or not always thinking about nurses first.

MR. FRANK: Yeah. I think the point made about -- that Sandra was making around interventions like Health Steps really highlights the role of community health workers, nurses so of master's level trained psychologists in sort of really playing that role of linking the behavioral to the general medical and pediatric.

MS. GILIBERTI: And, you know, Richard, the innovation center has done some modeling about things like diabetes when you invest early and see those outcomes that a state could capture those kinds of savings.

And we've often thought that maybe they should be modeling in this early

intervention, mother intervention, maternal health or early childhood sort of way and see the outcomes which, as we've said, we know will show good outcomes over time. So thinking about how we can use innovation models to really spur this forward.

MR. FRANK: Okay. I think we're getting pretty close to time. And I want to give anybody an opportunity for a parting shot, if you will. Chris, I'll give you first bibs.

MS. YOUNG: Sure. So I found this discussion so energizing and so great to talk with, you know, so many brilliant people about this topic. I think we have a unique moment here to make change. I think there is a lot of national attention focused on this product.

You see a ton of congressional attention to this issue right now. And I am so energized by this conversation and the degree of consensus that we seem to have across the country and the challenges that we need to address so that this is very optimistic that we can make some meaningful progress in the short term.

MR. FRANK: Anybody else? Hard to beat that actually. Okay. Well, I want to thank all of you for both the interesting, informative and lively discussion.

I hope the conversation for those of you who are watching from home or office has been informative and kind of helps you understand the significance in the proposals that are being kind of debated right now to address mental illness in the nation. And that are being put forth by the President. And I want to thank the panelists for their energetic participation and thank everybody in the audience for your focused attention. So thank you very much and please enjoy the rest of the day and stay safe.

\* \* \* \* \*

CERTIFICATE OF NOTARY PUBLIC

I, Carleton J. Anderson, III do hereby certify that the forgoing electronic file when originally transmitted was reduced to text at my direction; that said transcript is a true record of the proceedings therein referenced; that I am neither counsel for, related to, nor employed by any of the parties to the action in which these proceedings were taken; and, furthermore, that I am neither a relative or employee of any attorney or counsel employed by the parties hereto, nor financially or otherwise interested in the outcome of this action.

Carleton J. Anderson, III

(Signature and Seal on File)

Notary Public in and for the Commonwealth of Virginia

Commission No. 351998

Expires: November 30, 2024

ANDERSON COURT REPORTING  
1800 Diagonal Road, Suite 600  
Alexandria, VA 22314  
Phone (703) 519-7180 Fax (703) 519-7190