National Association for Behavioral Healthcare

Access. Care. Recovery.

31 March 2023

The Honorable Anne Milgram
Administrator
U.S. Drug Enforcement Administration
800 K Street, N.W. Suite 500
Washington, DC 20001

Re: Docket No. DEA-407

Submitted Electronically

Dear Administrator Milgram:

On behalf of the National Association for Behavioral Healthcare (NABH), we are writing to oppose regulatory revisions recently proposed (*Telemedicine Prescribing of Controlled Substances When the Practitioner and the Patient Have Not Had a Prior In-Person Medical Evaluation)* in which patients must be seen in person before a Schedule II stimulant medication and Schedule III-V medication for mental health disorders can be prescribed by a provider. We are concerned that reverting to pre-COVID-19 pandemic requirements will erode progress that has been made in the treatment of attention-deficit hyperactivity disorder (ADHD), depression, and anxiety in children, adolescents, and adults.

CDC estimates that between 2016 and 2019, the number of children 3–17 years ever diagnosed with ADHD is 6 million, including 265,000 children ages 3–5; 2.4 million children ages 6–11; and 3.3 million children ages 12–17. Furthermore, Black, non-Hispanic children and White, non-Hispanic children are more often diagnosed with ADHD than Hispanic or Asian, non-Hispanic children.[1] Serious deficits in education have been observed as a result of the pandemic. If children and adolescents do not have ready access to medications that allow them to stay in school, it will cause further erosion of academic progress. Furthermore, anxiety and depression have risen, and hospitals are increasingly crowded with children who are self-harming or suicidal, with an increase in hospitalizations from 30.7% in 2009 to 64.2% in 2019.[2]

At the same time, there is a workforce shortage of child psychiatrists. There are approximately 10,500 practicing child and adolescent psychiatrists in the United States. Ratios of child and adolescent psychiatrists per 100,000 children range by state from 4 to 65, with a national average of 14 child and adolescent psychiatrists per 100,000 children. [3]

Adults are also being affected with mental health symptoms and conditions. Depression tripled due to the COVID-19 pandemic and has not subsided: it went from 8.5% before the pandemic to 27.8% in early

[1] Centers for Disease Control and Prevention. *Data and Statistics About ADHD.* https://www.cdc.gov/ncbddd/adhd/data.html
[2] *Barry E. Hospitals Are Increasingly Crowded With Kids Who Tried to Harm Themselves, Study Finds. New York Times. March 28, 2023.*
[3] American Academy of Child & Adolescent Psychiatry. *Severe Shortage of Child and Adolescent Psychiatrists Illustrated in AACAP Workforce Maps*. May 2022.

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2020, and then worsened by April 2021, reaching 32.8%.[4] This is being met by overall shortages of mental health providers: 55% of counties in the United States have no psychiatrists,[5] and 130 million people live in areas with a shortage of mental health providers.[6]

Due to the relaxation of telehealth regulations during the COVID-19 pandemic, children and adolescents and adults in urban and rural areas were able to access Schedule II controlled substances via telehealth with their provider (particularly stimulants) and Schedule III-V controlled substances (particularly benzodiazepines and other psychotropics). The provision of mental health services is one of the healthcare areas in which telehealth rates have continued robustly post-COVID-19. Telehealth has stabilized at levels 38 times pre-pandemic levels; however, *psychiatry has seen the highest penetration among specialties at 50 percent.*[7]

While we appreciate that the DEA proposed rule allows for other DEA-registered providers to assist with the medical evaluations and referrals, a number of our members serve rural areas where patients often do not have a primary care physician who can assist with a medical evaluation. Moreover, poor access to behavioral healthcare is not just a rural issue. Patients in urban areas also often cannot access or pay for transportation and experience other barriers to receiving medical care.

One potential unintended consequence of the proposed change is that individuals will present to emergency departments to obtain the required medical evaluations for telehealth and/or for routine prescribing of controlled medications where care is not otherwise available. As you probably know, emergency departments are already overflowing with boarding of patients who have behavioral health concerns. Unfortunately, a lack of mental healthcare is the rule, not the exception, in the United States. Given the shortage of care providers across the nation, the new provisions will contribute to the overcrowding of hospital facilities with serious attendant consequences, including impacting "…correct, timely and efficient hospital care".[8]

The current DEA proposal does not strike the correct balance that ensures the continued availability of mental health care at a time when mental health concerns are paramount and we are in a mental health crisis.

Recommendations

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[4] Ettman CK, Cohen GH, Abdalla SM, Sampson L, Trinquart L, Castrucci BC, Bork RH, Clark MA, Wilson I, Vivier PM, GaleaS. *Persistent depressive symptoms during COVID-19: a national, population-representative, longitudinal study of U.S. adults*. The Lancet Regional Health – Americas. January 2022 (5).

[5] Mapping the supply of the U.S. Psychiatric Workforce, October 2018. School of Public Behavioral Health Workforce Research Center, University of Michigan.

[6] Larson, C. *Where the Mental Health Clinician Shortage is Worst*. Behavioral Health Business. June 24, 2022.

[7] Bestsennyy O, Gilbert G, Harris A, Rost, J. *Telehealth: A Quarter-Trillon-Dollar post COVID-19 reality? https://www.mckinsey.com/industries/healthcare/our-insights/telehealth-a-quarter-trillion-dollar-post-covid-19-reality*

[8] Savioli G, Ceresa IF, Gri N, Piccini GB, Longhitano Y, Zanza C, Picconi A, Esposito C, Ricevuti G, Bressan MA. *Emergency Department Overcrowding: Understanding the Factors to Find Corresponding Solutions.* J of Personalized Medicine. Feb 2022 12(2).

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1) We ask that the DEA remove all requirements for in-personal medical examinations for Schedule II stimulant medications for ADHD, and Schedule III-V mental health medications. We believe that existing guardrails adequately support safe prescribing of these medications, including adherence to the approved indications for these medications; limitations on refills; consultation with available information through state prescription drug monitoring programs (PDMP); and providers having a DEA license. At minimum, we request that the COVID-19 flexibilities be extended through calendar year 2023 while DEA further consults industry stakeholders on how to better implement the in-person medical evaluation requirement.

2) We also recommend that the DEA propose special registration regulations for an exception to the Ryan Haight Act's in-person exam requirement that would allow for the prescribing of controlled substances, as it would streamline requirements for prescribing controlled substances and provide deference to providers in their practice of medicine.

Pandemic policy changes increased sorely needed access to behavioral healthcare. Returning to pre-pandemic policies risks returning to an inequitable treatment system from which those with mental health conditions will suffer.

Thank you for your consideration.

Sincerely,

Shawn Coughlin
President and CEO

About NABH:
NABH represents the entire behavioral healthcare continuum – including provider systems that treat children, adolescents, adults, and older adults with mental health and substance use disorders in inpatient behavioral healthcare hospitals and units, residential treatment facilities, partial hospitalization and intensive outpatient programs, medication-assisted treatment centers, specialty outpatient behavioral healthcare programs, and recovery support services in 49 states and Washington, D.C.

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