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# EXAMINING OUR COVID–19 RESPONSE: USING LESSONS LEARNED TO ADDRESS MENTAL HEALTH AND SUBSTANCE USE DISORDERS

## HEARING

OF THE

## COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

## UNITED STATES SENATE

ONE HUNDRED SEVENTEENTH CONGRESS

FIRST SESSION

ON

EXAMINING THE RESPONSE TO COVID-19, FOCUSING ON USING LESSONS LEARNED TO ADDRESS MENTAL HEALTH AND SUBSTANCE USE DISORDERS

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# C O N T E N T S

## STATEMENTS

WEDNESDAY, APRIL 28, 2021

# EXAMINING OUR COVID–19 RESPONSE: USING LESSONS LEARNED TO ADDRESS MENTAL HEALTH AND SUBSTANCE USE DISORDERS

**Wednesday, April 28, 2021**

U.S. SENATE,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
*Washington, DC.*

The Committee met, pursuant to notice, at 10:02 a.m., in room 430, Dirksen Senate Office Building, Hon. Patty Murray, Chair of the Committee, presiding.

Present: Senators Murray [presiding], Casey, Murphy, Kaine, Hassan, Smith, Rosen, Lujan, Hickenlooper, Burr, Collins, Cassidy, Braun, Marshall, Scott, Romney, and Tuberville.

## OPENING STATEMENT OF SENATOR MURRAY

The CHAIR. Good morning. The Senate Health, Education, Labor, and Pensions Committee will please come to order.

Today we are holding a hearing on our Nation's mental health and substance use disorder crisis and how COVID–19 has made them worse. Ranking Member Burr and I will each have an opening statement, and then we will introduce today's witnesses. After the witnesses give their testimony, Senators will each have 5 minutes for a round of questions.

Before we begin, I, again, want to walk through the COVID–19 safety protocols that are in place today. We will follow the advice of the Attending Physician and the Sergeant at Arms in conducting this hearing. We are all, again, very grateful to our Clerks and everyone who has worked really hard to get this set up and help everyone stay safe and healthy.

Committee Members are seated at least 6 feet apart, and some Senators are participating by video conference. And while we are unable to have the hearing fully open to the public or media for in-person attendance, live video is again available on our Committee website at *help.senate.gov*. And if you are in need of accommodations, including closed captioning, you can reach out to the Committee or the Office of Congressional Accessibility Services.

This pandemic has taken a devastating toll. It has forced millions of people out of work and students out of school. It has taken over 570,000 of our loved ones, and the loss, the stress, the loneliness, the trauma it has caused is doing immense harm to our mental health. And it has been especially hard on our essential workers, healthcare workers, and others on the front lines of this crisis.

Around half of the adults in our Country say the stress and worry of this pandemic has impacted their mental well-being.

When it comes to our youth, what I am hearing from people in my state is incredibly alarming. Seattle Children's Hospital in Washington State is seeing 170 children with mental health emergencies a week, compared to 50 before the pandemic.

Sacred Heart Children's Hospital in Spokane saw admissions to its adolescent psychiatric unit and admissions to its pediatric floor for behavioral health issues both rise by around 70 percent.

Mary Bridge Children's Hospital in Tacoma has seen mental health admissions increase by two-thirds.

Central Washington Hospital saw a similar increase in non-fatal suicide attempts for minors, and suicides rates in King County are up 30 percent for youth.

When it comes to the issue of substance use disorder, a record 87,000 people, at least, are estimated to have died from drug overdoses in our Country over the last year. Overdose deaths in my state increased by 38 percent over the first half of 2020, with the biggest increases being among Black, Latino, and Tribal communities.

We must do more to address the tragic loss of life, as well as the terrifying effects we are learning COVID can have on mental health, with one study suggesting one-third of patients received a neurological or psychological diagnosis after their infection.

The challenge is not just that more people need mental healthcare in the wake of this pandemic. It is that too many people cannot get it. One-third of adults who say the pandemic has impacted their mental health also say there was a time this past year they did not get the mental healthcare they needed, most often because they could not afford it or they could not find a provider. And over half of high-risk children are not getting the mental healthcare they need, with the care furthest out of reach for Black children.

Of course, while these are serious problems, they are not new ones. Even before this pandemic, we were fighting epidemics of suicide, mental health issues, drug overdoses, with a health workforce that was stretched far too thin. Almost 120 million Americans live in areas with a mental healthcare provider shortage, essentially meaning they do not even have one mental healthcare provider per 30,000 people.

In Washington, our mental healthcare workforce is only able to meet 12 percent of our state's needs, and these challenges are especially hard on communities of color and rural communities, who often struggle the most to get mental healthcare.

As we work to recover from this pandemic and rebuild our Nation stronger and fairer, it is important we recognize mental health as a priority in our work. We have to address the unseen scars of trauma, depression, addiction, and other mental health issues. And, the reality is that healing those scars will not be quick or easy. It will take years, and we need to act accordingly.

When we passed the SUPPORT Act in 2018 to respond to the opioid crisis, I made clear it was only a first step and that I would be pushing for more action and more funding. This pandemic is a painful reminder that our work remains far from finished.

We need to make significant investments in programs that already exist to help our communities fight mental health issues and substance use disorders.

We need to make dedicated annual investments in our public health infrastructure and the local health departments on the front lines of these fights.

We need to make it easier for people to get the care they need by taking steps like President Biden announced yesterday to increase access to opioid use disorder treatment, and by looking at how to best use new tools, like telehealth, to reach more patients while ensuring quality and equity.

Steps Congress took in the CARES Act to temporarily expand access to telehealth services have made it easier for patients to get mental healthcare quickly, discretely, and conveniently. But, we cannot let the promise of telehealth be limited by a lack of access to broadband, especially in our rural communities and communities of color, and a lack of mental healthcare professionals to keep up with the demand for that care.

We must also remember that telehealth is no replacement for making sure people have quality, affordable providers in their own communities, which is why we need to recruit, train, and retain enough mental healthcare professionals to actually meet our Nation's needs and make sure they practice in underserved communities.

I hope we will be able to work in a bipartisan way to tackle these challenges.

Finally, any good doctor knows you cannot just treat the symptom; you have to look at the root causes. We need to help people get the care they need for stress and anxiety and depression and more. But, we also need to address the issues that have caused so much pain this past year, and that includes not only the pandemic, but systemic racism, gun violence, and an economy that works great for those at the top, but it does not work well for anybody else.

I look forward to the work our Committee can do on these issues, and mental health and substance use disorders. We have a record of bipartisan work on some of this already, and I am going to continue to press for action.

With that, I will recognize Ranking Member Burr for his opening remarks.

## OPENING STATEMENT OF SENATOR BURR

Senator BURR. Well, thank you, Madam Chair, and I thank you for holding this hearing today.

Over the last year, we put in place measures to slow the spread of coronavirus. This new virus quickly escalated from an outbreak in China to a pandemic that has challenged countries around the world, including the United States. While these measures were put in place to ensure our health system could weather the storm, these measures in the pandemic have in many ways asked so much of Americans.

Families with critically ill and dying loved ones have not been able to visit their parents, grandparents, and siblings, instead, say-

ing goodbye over video. This has compounded the grief for so many and taken a tremendous toll on healthcare professionals.

Sacrificing simple acts, like hugging our family members, neighbors, and feeling a sense of purpose when we walk into the office every day have consequences on our mental health.

A year of sitting 6 feet apart, canceling weddings, holidays, adjusting to remote school has had an effect on the well-being of every American. We must continue to examine these effects as part of our review of the COVID response.

Our current surgeon general has written a lot about the effects of loneliness. He has explained that this lack of human connection can lead to depression, anxiety, and chronic conditions, like heart and dementia.

It is no surprise to me that after a year of being apart, we are seeing the heartbreaking effects of separation and sacrifice. Prior to the pandemic, experts estimated that one in four adults in the United States had a mental health disorder, and we were also in the midst of responding to an opioid crisis.

The need to respond to these challenges continued during COVID–19. Reaching people and providing care required innovative approaches from doctors, nurses, and other healthcare providers all around the Country. I look forward to hearing about those solutions from our witnesses today.

We are a resilient Country. I believe that the most important action we can take to help people is to reopen as much of the Country as quickly and safely as possible. Bring back hope to the American people. Let neighbors celebrate birthdays and milestones, and let students see and interact with their peers.

My State of North Carolina is taking an important step in this process, announcing plans to lift COVID restrictions on June 1 if our metrics continue to show the progress against the virus that it has to date. Vaccinations are a key metric.

We have got to look at the next few weeks and months down the road to address the next phase of response—getting more shots in arms. The return of the Johnson & Johnson vaccine is an important part. And I am glad that CDC and FDA finally reaffirmed the safety and efficacy of that shot, but I am worried about the ham-handed way they handled it. This has led to even more vaccine hesitancy than before. Americans should know that the benefits of using the vaccine far outweigh the potential risk.

Now, with 37 percent of adults fully vaccinated, we are seeing the demand slow. So, painting a picture of benefits of all three vaccines—Pfizer, Moderna, and Johnson & Johnson—will be important to driving down our infection rate and improving our chances of a recovery.

Getting back to work is a big part of that picture, and we cannot do that until children are in daycare or in school.

The reopening of our restaurants, our ballparks, and small business mean more opportunities for Americans to return to activities they love, but it also means more jobs and more opportunities to restore their livelihoods.

We invited the witnesses here today because they have seen the mental health effects of the pandemic and the response in their communities firsthand, but also because they have raised their

hands with local solutions. I look forward to hearing about those local solutions today and how they can help to accelerate our Country's broader recovery from COVID.

Our message and the message of this Administration should be that we are willing to have teachers and students back in classrooms safely this fall; that Main Street is open; that Thanksgiving plans are on the books; and that this summer, you can even attend a ball game with certain precautions. Even if things look a little different, life can almost become normal.

I thank the chair.

The CHAIR. Thank you, Senator Burr.

We will now introduce today's witnesses, starting with Senator Casey, who will introduce Dr. Benton.

Senator CASEY. Thank you, Chair Murray.

I am pleased to introduce Dr. Tami Benton and grateful for the expertise that she brings to this hearing today. In addition to her decades of service caring for children and families in my home State of Pennsylvania, Dr. Benton is Psychiatrist-in-Chief and Chair of the Department of Child and Adolescent Psychiatry and Behavioral Sciences at America's first pediatric hospital—The Children's Hospital of Philadelphia, more commonly known at CHOP.

She also directs the Child and Adolescent Mood Program and the Youth Suicide Center at the Perelman School of Medicine at the University of Pennsylvania.

Her clinical and research expertise focuses on pediatric depression, suicide, and anxiety, particularly for minority youth and those with chronic diseases.

She also has developed expertise on the crisis of our mental health workforce shortage and potential solutions.

We want to thank Dr. Benton for all that you and your team have done to meet the increased needs of families during this pandemic and for sharing your insights with us today. Welcome to the hearing.

The CHAIR. Thank you, Senator Casey.

Dr. Benton, glad to have you here with us today, or here on video today with us.

Now, Senator Scott will introduce Dr. Goldsby.

Senator SCOTT. Thank you, Madam Chair, and thank you to all the witnesses for being here with us today.

It is my privilege to introduce Sara Goldsby, who serves as the Director of South Carolina's Department of Alcohol and Other Drug Abuse Services. Having led the agency since 2016, in her current role, Ms. Goldsby oversees the state's opioid responsive efforts, co-chairing the State Opioid Emergency Response Team. Her agency has played a pivotal role in combatting the opioid crisis, particularly as the COVID–19 pandemic has exacerbated some of its most troubling effects.

As the virus and related restrictions escalated, mental health challenges and substance use disorders, the department responded decisively and comprehensively, supporting telehealth service delivery and promoting virtual education and outreach, in addition to ramping up naloxone distribution in order to address emergency overdoses.

Through a wide range of initiatives, partnerships, and localized solutions, the department has served as a vital asset and a national model, particularly in recent months.

In recognition of Ms. Goldsby's exceptional work at the department, she received the 12th Annual Ramstad/Kennedy Award for Outstanding Leadership, among other accolades.

Thank you, Ms. Goldsby, for your service to South Carolina, and thank you for participating in this crucial conversation. I look forward to your testimony.

The CHAIR. Thank you very much, Senator Scott.

Dr. Goldsby, welcome. We look forward to your testimony.

Next, I am pleased to welcome Dr. Andy Keller. Dr. Keller is the President and CEO and Linda Perryman Evans Presidential Chair of Meadows Mental Health Policy Institute in Dallas, Texas. And, he is also a licensed psychologist with more than 20 years of experience in behavioral health policy.

Dr. Keller, welcome.

He also said, told me this morning, that his family is from my home state. So, we are especially glad to have you here today, Dr. Keller. Welcome.

Next, I will turn it over to Senator Hickenlooper to introduce Dr. Jonathan Muther.

Senator HICKENLOOPER Thank you Chair Murray and Ranking Member Burr for inviting me to introduce Dr. Jonathan Muther to testify today.

Dr. Muther is from the great State of Colorado, of course, where he is Vice President of Behavioral Health at Salud Family Health Centers in Fort Lupton, Colorado. He practices at the Commerce City Salud Clinic. Salud Family Health Center is one of my favorite organizations in Colorado, a federally qualified health system with 13 community health clinics in eight counties in Colorado, doing critical work all the time.

Dr. Muther serves as a Clinical Integration Advisor at the Eugene Farley Health Policy Center at the University of Colorado.

Dr. Muther's specialty is integrated primary care. Psychology is also involved in direct patient care training and supervision, as well as program development and evaluation. And, as you will all see today, he is passionate about advocacy for healthcare policy change. His primary areas of interest are working with traditionally underserved communities by improving access to existing systems and working with the Spanish-speaking population.

Dr. Muther is also committed to addressing life stress and the full spectrum of mental illness, behavioral interventions, and evaluating health outcomes.

I am really delighted that Dr. Muther could be with us today to discuss these critically important issues around behavioral health, and particularly among kids and underserved communities across Colorado and across the Country.

Thank you, Chair Murray, Ranking Member Burr, and all the Members of the Committee. I am really looking forward to the hearing today.

The CHAIR. Thank you, Senator Hickenlooper.

Thank you Dr. Muther for joining us today.

Thank you to all of our witnesses for taking the time today to share your experiences with all of us.

With that, we will begin your testimony. Dr. Benton, let's start with you. You may begin with your opening statement.

**STATEMENT OF TAMI D. BENTON, M.D., PSYCHIATRIST-IN-CHIEF AND EXECUTIVE DIRECTOR AND CHAIR OF THE DEPARTMENT OF CHILD AND ADOLESCENT PSYCHIATRY AND BEHAVIORAL SCIENCES, CHILDREN'S HOSPITAL OF PHILADELPHIA, PHILADELPHIA, PA**

Dr. BENTON I would like to thank Chair Murray, Ranking Member Burr, and distinguished Members of the Committee for this opportunity to share my knowledge about what is happening in the crisis of children's mental health right now from my boots-on-the-ground perspective.

As Chair Murray mentioned, there has been a crisis of children's mental health for some time, but the pandemic has made it all much worse. Just recently, I was called to our emergency department to see a youngster whose family had arrived, expressing concerns about her suicidal ideation and threats to run into traffic to end her life. But, I was very surprised when I arrived to find that this youngster was only 5 years old. And when I asked her what she thought would happen when she died, she responded that, I will come back tomorrow and I will be a good girl, and my parents will be happy again.

This was a family where the parents had recently lost their employment through COVID–19. The mother was struggling with depression. A previously resilient family, who were just stressed by the demands of this pandemic, unable to provide care for their own youngster.

But, even more disturbing to me was my inability to provide an appropriate avenue for care for this youngster and her family. There were no inpatient or outpatient options available for her care that I could find. There was no place for this youngster and their family to receive the care that they deserved. My options were to place this child in an inpatient pediatric medical facility, but an inpatient bed, as the only avenue for keeping her safe and providing an opportunity for reuniting with her family.

The option that I provided for her maintained safety, but did not provide the care that she needed and prevented other children from having a medical bed that was desperately needed during that time.

I wish that I could say that this story was an uncommon one, but it is increasingly common in our emergency departments. We are seeing surges in volumes with young people—30 to 50 percent increases in our own facilities, similar to those that Chair Murray described, with young people who previously had no mental health conditions appearing now with concerns about depression, anxiety, eating disorders, and suicidal ideation and behavior.

The stories around disposition and placement, where can kids go for treatment, sometimes require that we are transporting them across state lines to receive the care that they deserve.

I must admit, at times, these challenges seem very overwhelming, but I know that there are solutions to these problems.

First, telehealth has provided an opportunity for us to reach populations across the United States, minoritized populations and rural populations, previously vulnerable due to access to care. We should continue to support the opportunities for providers to provide care across state lines so young people can receive care where they need it.

There is also opportunities for us to continue to support care in the community so our community mental health programs, our primary care practices, school mental health, places where children can receive their care in their communities, with their families, where they belong.

Other opportunities for us are opportunities to support a continuum of care so that young people, like the five-year old I described, would be able to get the outpatient or intensive outpatient or day hospital or acute inpatient treatment that she deserved in an appropriate facility. And, our payment structures must be aligned to provide families to have access to these levels of care.

I believe that if we—finally, I want to mention the other topic that Chair Murray mentioned, which was the shortage of providers, which is a longstanding challenge in mental health. So, we know that there is an estimate of about 15 million children who are requiring mental health services. There are about 8 to 9,000 child psychiatrists to serve the most severely impacted, but there are shortages of psychologists, social workers, nurse practitioners, nurses, community mental health workers who could address some of the need. And loan forgiveness would allow these professionals to remain in the workforce to provide this care.

I believe that if we approach these solutions together, the result will be that young people can stay in their communities where they receive their care, where we can do prevention before things become a crisis. If we are successful, children will be treated in their communities, in their homes, with their families and their friends, in their schools, where they belong.

We do know that we anticipate—we do know from the data that we are collecting thus far that we anticipate the impacts of this pandemic to far exceed the time period by which we actually get control over this virus. But, we have opportunities to be prepared. If we plan together, if we implement the solutions recommended, we will be able to prevent severe illness and protect the mental health of young people in our Nation.

Thank you.

[The prepared statement of Dr. Benton follows:]

PREPARED STATEMENT OF TAMI D. BENTON

Chair Murray, Ranking Member Burr, and Members of the Committee:

My name is Dr. Tami Benton. I am Psychiatrist-in-Chief and Chair of the Department of Child and Adolescent Psychiatry and Behavioral Sciences at Children's Hospital of Philadelphia (CHOP) and the Frederick Allen Professor of Psychiatry at the Perelman School of Medicine at the University of Pennsylvania. I also serve as director of the Child and Adolescent Mood Program and the Youth Suicide Center at CHOP, a multidisciplinary clinical and research program focused on depression and suicide among children and adolescents, with an emphasis upon minority youth. Thank you for the opportunity to testify today about the effects the COVID–19 pandemic has had on the mental health of our children and youth.

Children's Hospital of Philadelphia (CHOP) was founded in 1855 as the Nation's first pediatric hospital. Through its long-standing commitment to providing excep-

tional patient care, training new generations of pediatric healthcare professionals, and pioneering major research initiatives, Children's Hospital has fostered many discoveries that have benefited children worldwide. Its pediatric research program is among the largest in the country. In addition, its unique family centered care and public service programs have brought the 595-bed hospital recognition as a leading advocate for children and adolescents.

The Department of Child and Adolescent Psychiatry and Behavioral Sciences at CHOP provides emotional and behavioral health services for infants, children and teens. Our experts conduct thorough evaluations with all patients and use a biopsychosocial model to identify biological, environmental, psychological and academic factors that contribute to a child's condition. We focus on the experience of your whole family by involving everyone in the evaluation process and care planning, and conduct research focusing on all aspects of mental, emotional and behavioral health, including efforts focused and preventing a child with elevated symptoms moving into crisis.

There were extreme shortages in pediatric behavioral health prior to the pandemic and access to care was further complicated by high demand and complicated payor networks. It is estimated that 1 in 6 U.S. children between ages 2–8 years have a diagnosed mental, behavioral or developmental disorder.[1] Unfortunately, COVID–19 has exacerbated the mental health stress on children and youth, highlighting the Nation's acute shortage of mental health services and the need to reinforce and expand the pediatric mental health delivery system and infrastructure. According to a November 2020 report by the CDC, between March and October 2020, the number of mental health visits for adolescents ages 12 to 17 was 31 percent higher than over the same period in 2019; for children ages 5 to 11, it was up 24 percent.

The pandemic also has highlighted significant disparities related to access to mental health services, particularly in underserved communities. Studies show the limitations of the current system is affecting all children, but minority children, particularly Black and Hispanic children often face inequitable access to and continuity of care. As a result, these children are more likely to present in the emergency rooms for mental health issues and less likely to access child and adolescent psychiatrists and other mental health professionals in the community.

Emerging data about long term impacts of the pandemic on children's mental health suggest that we will continue to see the heightened impact on youth mental health for some time. Like other children's hospitals, CHOP is seeing increasing numbers of children and families coming to the emergency department (ED) in crisis. Our psychiatric emergency visits have increased by 60 percent over the last few years. Since the onset of the pandemic, more than 30 percent of our ED visits are resulting in hospitalizations for psychiatric treatment. When the pandemic struck, we Initially saw an overall decline in emergency department visits due to COVID-related restrictions, but we are now seeing a surge of children and adolescents coming to the ED. These patients come to us at a greater level of acuity, requiring more immediate, intensive treatments as well as hospitalizations. Those impacted the most have been youth with autism and other neurodevelopmental disabilities, as well as those with depression, anxiety and eating disorders.

Many of the children that we are seeing were managing well in their communities before the pandemic, receiving care in their local mental health agencies, schools and primary care offices but are now presenting for emergency care due to worsening symptoms. We are also seeing some shifts in the ages of young people who are seeking mental health treatment. More children between the ages of 6–12 years are complaining of severe anxiety, depression and suicidal feelings. We are also starting to see large numbers of children and adolescents who had no prior mental health concerns showing up in the emergency department in larger numbers due to disruptive behaviors, anxiety, depression, suicidality and eating disorders. Families who were resilient and effective before the pandemic are struggling to manage children's emotions while facing remote learning, work-related changes and their own emotions during these times.

Even before COVID, the shortage of options, particularly across the continuum of care, were staggeringly limited. It is, in fact, hard to overstate this concern. One clear indicator is that we and other children's hospitals nationwide often are forced

[1] Cree RA, Bitsko RH, Robinson LR, Holbrook JR, Danielson ML, Smith DS, Kaminski JW, Kenney MK, Peacock G. Health care, family, and community factors associated with mental, behavioral, and developmental disorders and poverty among children aged 2–8 years—United States, 2016. *MMWR*, 2018;67(5):1377–1383.

to send children covered by Medicaid several states away so they can access appropriate care not available closer to home. Needless to say, this separation from family, community and regular health care providers is inadvisable.

The increased stress experienced by families during the pandemic occurred at the same time that mental health services became more limited because of COVID-related restrictions on access to hospitals and primary care clinics. Requirements for social distancing, as well as COVID outbreaks among staff and children in these facilities, reduced capacity even further. These challenges increased the demand for emergency and crisis services such as inpatient psychiatric settings as lower levels of care were unavailable, even to those children for whom another setting would have been more appropriate.

One important but unforeseen outcome has been that children with mental health concerns are being admitted to pediatric medical facilities while awaiting psychiatric inpatient care and treatment. This is not only contrary to the treatment for that child but also nearly always means they are in a bed that a sicker child needs. If the system were not overloaded, specifically designated crisis centers would provide evaluation and placements for children and youth in mental health crisis. Now, families turning to these centers can find themselves waiting, sometimes for days, to have any assessment, let alone an appropriate care placement. Many of these families understandably go to the ED instead. As a result, at CHOP, where 95 percent of the behavioral health care is provided in outpatient settings, we have up to 50 patients waiting for mental health beds on any given day. As we typically operate at capacity, this means that we cannot use that space for a child with more complex medical needs.

To address this, we are in the process of expanding our services in the hospital and our community. Even doubling our outpatient capacity, partnering with other providers to address the full continuum of needs and looking into establishing inpatient capacity, does not fully meet the demand for care. While not the primary problem, regulatory hurdles, including the restrictions on the colocation of adult and pediatric services make it difficult to collaborate with other providers to use existing space to meet the ever-growing needs of our community.

**Recommendations**

The good news is that there have been lessons learned during the pandemic that will help advance children's mental health care going forward. We recommended retaining those things that have effectively supported access to care, while addressing other issues that have been long-standing.

First, care provided in communities through schools and primary care clinics provides the opportunity for early identification and intervention for children and families with mental health challenges at the right level and at the right time. We must invest in care in these settings as the continuity of relationships between children, families, care providers and educators helps address mental health challenges before they become crises. Effective families and effective schools are two of the most important elements for building resilience, prevention of poor mental health outcomes and promotion of effective, psychologically healthy children.

Second, we strongly recommend making permanent the telehealth flexibilities allowed during the pandemic, particularly those that would allow providers, including Medicaid providers, to care for patients across state lines. Bills like the Temporary Reciprocity to Ensure Access to Treatment (TREAT) Act, which would provide temporary licensing reciprocity for health care professionals for any type of services provided to a patient located in another state during the COVID–19 pandemic, can help us serve patients wherever they are located, and we encourage Congress to pass that legislation.

Telehealth has significantly advanced our ability to reach more patients and to engage them in treatment. CHOP providers have completed more than 238,000 telehealth video visits with over 108,000 unique patients since the onset of the pandemic. The departments utilizing telehealth most frequently are general pediatrics (46,000 visits) and behavioral health (44,000 visits). Through telehealth, patients have been able to receive care in their homes, preventing the travel time and costs. While in-person visits are still required, the expansion of telehealth services has enabled us to reach more youth and families, made it easier for them to participate in care, expanded our reach to vulnerable underserved populations and increased families' abilities to keep their appointments, which, in turn, helps us maximize the limited resource that is mental health service providers.

Telehealth has been a boon in other ways. Notably, it has allowed increased family engagement and participation, empowering and supporting families to be able to support their children's emotional health. Clinicians can also provide expertise for areas of severe shortages by consulting with community clinicians via telehealth as well as school psychologists and counselors. Areas with severe shortages of mental health clinicians can utilize consultations with clinicians in areas where there are more providers with appropriate expertise, if we can ensure that there is broadband access for rural and other underserved areas to make such collaboration accessible.

Behavioral telehealth provides so many advantages to children, families and providers that it should be a not only permitted but required in Medicaid programs. Also, to allow for appropriate sharing of health information between school psychologists and a student's external health team and thereby maximize coordination among caregivers, educators and families, it will also be important to harmonize the education and health care privacy standards. [2]

Third, we must address workforce challenges. According to the American Psychiatric Association, there are an estimated 15 million children and adolescents nationwide in need of care from mental health professionals. However, there are just 8,000 to 9,000 psychiatrists treating children and teenagers in the United States, and shortages abound across other pediatric mental health professionals as well. There are severe shortages of child and adolescent psychiatrists, impacting care for youth with the highest levels of need. But there are also shortages of mental health therapists, nurse practitioners, case managers and community mental health workers who are all needed to expand access to mental health care. All of these professions could benefit from loan forgiveness programs to incentivize participation in these fields.

But efforts to strengthen the pediatric behavioral health workforce must go beyond attracting new mental health providers at all levels to include cross-training current providers. Improvements could include broadening the skills of the primary care workforce, ensuring school psychologists use evidence-based techniques, properly training psych techs and psychiatric nurses, as well as adding many more licensed clinical social workers to the workforce.

Finally, we must advocate for changes to payment structures that support the full continuum of care necessary to address the mental, emotional and behavioral distress our children face. Getting this right will mean children receive the care they need at the appropriate level, maximizing the likely success of the treatment, ensuring that they are taking a higher acuity spot desperately needed by another child, and more wisely spending health care dollars.

Greater payment parity in Medicaid for mental, emotional and behavioral health services, would make it possible to resource the continuum of care our children and youth need, such as intensive outpatient, partial hospitalization and limited residential treatment facilities—and, importantly, bring that care closer to home.

An investment in earlier treatment is also needed. In particular, we must continue to improve access to care in the community through schools and primary care in order to identify mental and behavioral health problems early, before crises emerge. If we prevent a crisis, we not only improve the health of our Nation's children, but also decrease unnecessary utilization of costly services.

Improvements in these areas would improve the care of our Nation's children, empower families and schools to promote the emotional health of our children, provide the right level of care to those in need, and reduce unnecessary utilization of costly emergency and hospital services.

Children throughout America are in crisis. Unlike many physical illnesses, mental health illnesses are not often visible to the untrained eye. While conversation about mental health is becoming more comfortable, there are still many children and their families who need help but choose to stay silent for fear of embarrassment. By elevating the dialog here, in Congress, and providing the resources they need, you can help us treat these children and provide them with a pathway toward resilience and happiness.

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[2] The Health Insurance Portability and Accountability Act (HIPAA) and the Family Education Rights and Privacy Act (FERPA) have differing privacy standards, limiting information sharing and creating barriers to care.

[SUMMARY STATEMENT OF TAMI BENTON]

There were extreme shortages in pediatric behavioral health services prior to the pandemic. Unfortunately, COVID–19 has exacerbated these shortages. The increased mental health stress on children and youth has brought a spotlight on the Nation's acute shortage of mental health services and highlighted significant disparities related to access to mental health services, particularly in underserved communities. The need to reinforce and expand the pediatric mental health delivery system and infrastructure is now overwhelming.

Similar to other children's hospitals across the country, we are seeing increasing numbers of children and families coming into the emergency department in crisis. While there has been an increase over the past 2–3 years, the numbers have severely escalated during the pandemic. In particular, we have experienced surges in the volumes of children and families who are presenting for emergency care, including those who had previously received care in their schools or local pediatric care facilities. This increased demand for mental health treatment coupled with the preexisting shortages of trained mental health professionals has only worsened the barriers to access for children, adolescents and their families seeking mental health care.

Despite the challenges imposed by the pandemic, there were successes in our efforts to increase access to care for children and families. Flexibilities that allowed rapid telehealth expansion provided access to care that did not exist before the pandemic. Using these new capabilities, we were able to reach populations of youth and their families to provide care while families could not leave the safety of their homes. We were also able to provide education for families and teachers using telehealth for psychoeducation sessions, better arming them to address children and adolescents' challenges. Since the initiation of telehealth services, we have been able to reach more youth and families, both making it easier for them to participate in care and increasing our rates of families keeping their appointments, which helps us better utilize the too limited mental health workforce.

The past year has provided us with important lessons to draw from as we seek to advance children's mental health care. Going forward we must work to strengthen care provided in communities through schools and primary care clinics; make permanent the telehealth flexibilities allowed during the pandemic, particularly those that would allow providers, including Medicaid providers, to care for patients across state lines; address workforce challenges by attracting new mental health providers and cross-training current providers; continue to support parents and educators of children with mental and behavioral health issues; and work to improve payments structures and reimbursement for pediatric providers.

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The CHAIR. Thank you, Dr. Benton.

Dr. BENTON. Thank you.

The CHAIR. We will turn now to Dr. Goldsby.

**STATEMENT OF SARA GOLDSBY, MSW, MPH, DIRECTOR, SOUTH CAROLINA DEPARTMENT OF ALCOHOL AND OTHER DRUG ABUSE SERVICES, COLUMBIA, SC**

Ms. GOLDSBY. Thank you. I would like to thank and acknowledge Senator Scott for the gracious introduction. We are proud and grateful here for his work in Washington.

Chair Murray, Ranking Member Burr, and Members of the Committee, my name is Sara Goldsby, and I serve as Director of South Carolina Department of Alcohol and Other Drug Abuse Services. I also serve as Vice Chair of the Public Policy Committee of the National Association of State Alcohol and Drug Abuse Directors, or NASADAD. It is a privilege to join you today.

First, thank you for your leadership on substance use disorder issues. We appreciate your work on CARA, the 21st Century Cures Act, the SUPPORT Act, along with historic investments in SAMHSA and its Substance Abuse Prevention and Treatment, or SAPT Block Grant.

The COVID–19 pandemic has exacerbated substance use disorders, and in our state, like all others, we have certainly felt the impact.

We saw a 27 percent increase in alcohol sales for the period of March 15 to June 30, 2020 when comparing the same months during the previous years.

From April to June of last year, calls to our department's help line seeking help for substance use disorder services spiked anywhere from 25 to 35 percent.

Provisional mortality data from the CDC predicts 1,625 South Carolinians died of drug overdose during a 12-month period ending in September 2020. That represents a 45.3 percent increase over the same period in 2019. Over 62 percent of those predicted overdose deaths were attributed to illicitly made, synthetic opioids, including Fentanyl.

When the pandemic hit, our department knew we had to take action, and we did. We transitioned to support telehealth service delivery for crisis management, individual psychotherapy, case management, and other services delivered virtually or by phone.

We allocated state funds to providers to purchase cell phones and data plans for those patients in need.

We partnered with our Department of Mental Health to market and launch the SC-HOPES line, a toll-free line open 24/7 for callers to access licensed mental health and addictions counselors.

With the help of SAMHSA and DEA, we authorized 14-day and 28-day take-home doses of methadone for all of the nearly 7,000 patients in our state who were stable in treatment.

We shipped between 6,500 and 7,000 boxes of Narcan to our community distributors, including recovery community organizations. We also unveiled the 1, 2, Breathe public education campaign to demonstrate the effectiveness, availability, and accessibility of Narcan.

We initiated the Pause Campaign to encourage parents to use this unprecedented pause in our daily lives to talk with their kids about the risks and dangers of prescription drugs.

We used drive-thru events and food distribution programs to share Deterra packets for safe medication disposal.

We distributed educational materials on the importance of prevention.

We worked with our recovery community organizations, as well, to support the transition of peer recovery services to virtual formats.

In sum, we implemented an array of initiatives across the continuum to serve those struggling with or at risk for substance use disorders.

Now I would like to offer a few recommendations. First, please work to ensure that Federal policy initiatives and Federal funding for substance use disorders flows through state alcohol and drug agencies. This approach will ensure effective planning, implementation, oversight, and accountability. State alcohol and drug agencies ensure evidenced-based practices and quality through standards of care and technical assistance to providers.

Second, we recommend a transition over time from drug-specific grants to continued investments in SAMHSA's SAPT Block Grant.

While we are incredibly grateful for the opioid-specific funds directed to state alcohol and drug agencies, such as the State Opioid Response Grant, states would benefit from more flexibility to address all substances of concern.

Third, we recommend maintaining a number of the flexibilities that accompany the Public Health Emergency Declaration. We hope that each category can be studied with an eye on permanent changes for those found to be effective.

Fourth, please maintain a strong SAMHSA. We believe SAMHSA should be the default agency for all Federal substance use disorder programming. We appreciate the work of Tom Coderre, SAMHSA's Acting Assistant Secretary, and we fully support President Biden's recent nomination of Dr. Miriam Delphin-Rittmon, Connecticut's State Director and NASADAD member, to serve as the permanent leader of SAMHSA.

Fifth, we hope resources could be provided to states to support recovery housing, broadband, and hardware and software needed to ensure all have access to critical services.

Finally, we hope this Committee will consider the work done in CARA 3.0, which was introduced by Senators Whitehouse, Portman, and others. We appreciate, for example, Section 211 of that bill that would create a grant program within SAMHSA to help states bolster their primary prevention workforce.

Again, thank you for the opportunity to join you today, and I will be happy to answer your questions.

[The prepared statement of Ms. Goldsby follows:]

PREPARED STATEMENT OF SARA GOLDSBY

Chair Murray, Ranking Member Burr, and members of the Committee, my name is Sara Goldsby, and I am Director of the South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS). I also serve as Vice Chair of the Public Policy Committee of the National Association of State Alcohol and Drug Abuse Directors, or NASADAD.

I truly appreciate the opportunity to testify before you today to discuss the impact of the COVID-19 pandemic on substance use in South Carolina, the State's actions to mitigate the impact, and the tremendous help we have received from Congress, the White House, and federal agencies like the Substance Abuse and Mental Health Services Administration (SAMHSA).

## Role of the State Alcohol and Drug Agency

**Critical Role of the State Alcohol and Drug Agency:** Each State's alcohol and drug agency plays a critical role in overseeing and implementing the publicly funded prevention, treatment, and recovery service system.

Planning: All State alcohol and drug agencies develop a comprehensive plan for service delivery and capture data describing the services provided. Our agency does this in a number of ways. Each year, we require a strategic plan to address alcohol and other drug issues from each county alcohol and drug abuse authority. These plans are required to follow the strategic prevention (or planning) framework and must consider the most updated data available for a needs assessment. As we understand each county's unique needs, capacity, and strategies to address substance use issues, we then create a State plan for service delivery supported by federal and State funds available through our office. Additionally, we support the State Epidemiological Outcomes Workgroup (SEOW), composed of statisticians, epidemiologists, and data holders across State agencies. The SEOW's annual reports on prevalence and burden of substance use in our State inform priorities for planning and are shared with stakeholders Statewide. Finally, we co-lead the State's Opioid Emergency Response Team that develops and manages the emergency plan to address the opioid epidemic across sectors in the State.

Managing the Substance Abuse Prevention and Treatment (SAPT) Block Grant: State alcohol and drug agencies manage the Substance Abuse Prevention and Treatment (SAPT) Block Grant, which is administered by SAMHSA. The SAPT Block Grant serves as the cornerstone of the publicly funded service delivery system and helps support the delivery of prevention, treatment, and recovery services. The SAPT Block Grant serves as an efficient mechanism through which federal resources can be invested into substance use disorder services. State alcohol and drug agencies use SAPT Block Grant funds in a flexible manner to address all substance use disorders, utilizing State-level data and trends to inform their allocation decisions.

Ensuring Quality: An important focus of State alcohol and drug agency directors across the country is the promotion of effective, high-quality services. In South Carolina, we expect our providers to implement evidence-based screening tools and to use American Society of Addiction Medicine (ASAM) placement criteria to ensure patients are placed in the appropriate level of care. All of our contracted treatment providers are required to maintain either accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). We also conduct real-time compliance checks year-round with ongoing reviews of the clinical charts of all of our contracted treatment providers. This is to ensure compliance with best practices and Medicaid standards. We require our providers to use evidence-based services across the continuum – including

prevention services – and support community programs that use the strategic prevention framework process. We ensure our contractors' use of evidence-based data from trusted sources and informed practices that we approve. We support our providers year-round with training and technical assistance as requested and as we deem appropriate.

Coordinating with Other State Agencies: State alcohol and drug agencies work collaboratively across State governments to ensure that addiction issues are addressed with a coordinated, cross-agency approach. For example, the State alcohol and drug agencies work with State departments of mental health, criminal justice, child welfare, education, and more. Because alcohol and drug issues cross every sector and impact citizens Statewide, we partner closely with the other public health and social service agencies in South Carolina.

We engage in daily communication with the S.C. Department of Health and Environmental Control (SCDHEC) for situational updates, data sharing, and on a number of joint projects, including HIV education and early intervention services, as well as overdose prevention programming for law enforcement officers and firefighters. We also employ liaison staff that bridge our agency with others. Our Certified Peer Support Specialists are employed by DAODAS but are stationed at the S.C. Department of Corrections (SCDC) as they conduct peer trainings for inmates and coordinate inmates' access to treatment and services upon their re-entry to the community. The liaison who works between our agency and the S.C. Department of Social Services (SCDSS) helps develop policy and programming for children and families in the social services system who are affected by alcohol and other drugs. This bridge has helped align best practices and good policy across two large public systems. Our liaison at the S.C. Department of Mental Health (SCDMH) is responsible for coordinating training for co-occurring mental and substance use disorders across the State's community mental health centers and our county alcohol and drug abuse authorities. This work is helping our State achieve a "no wrong door" approach to serving citizens experiencing both mental health and substance use issues. Furthermore, we have a formal partnership for projects to address veterans with our state Department of Veterans' Affairs (SCDVA). Additionally, we have a contract with the S.C. Department of Probation, Parole, and Pardon Services (SCDPPPS) to train their officers on substance use disorders and evidence-based screening. Finally, I am in contact most days with the Major over Narcotics at the S.C. Law Enforcement Division as we share information on trends, trafficking, and State policy.

Unique Relationship with Providers: State alcohol and drug agencies play a critical role in supporting the substance use disorder provider community. Our staff are in regular and routine contact with staff at provider organizations. Leadership at DAODAS meets monthly with all of the directors of the county alcohol and drug abuse authorities during their monthly association meeting. The managers of DAODAS' Divisions of Treatment & Recovery Services and Prevention & Intervention Services meet quarterly with the local Treatment Directors and Prevention Coordinators, respectively, for training and global communication, but they also connect one-on-one for assistance and support as needed. Our State Opioid Treatment Authority (SOTA) meets quarterly with the directors of the State's opioid treatment programs (OTPs) to discuss services and policy related to methadone services. Additionally, these directors and their program coordinators are routinely in touch with the SOTA for one-on-one assistance as needed. Our Finance & Operations team meets quarterly with the treatment providers' finance managers, and they make time twice a year for one-on-one calls to answer questions regarding bookkeeping, reimbursement, and other financial operations issues. Our Recovery Services

Coordinator is in close contact with the leaders of the recovery community organizations (RCOs) around the State, offering support and technical assistance as they establish programs and grow. Before the COVID-19 pandemic, our staff often traveled to provider sites for visits and in-person program reviews. In South Carolina, we consider our agency and our providers to be a system with mission-driven connectivity that cannot be broken.

## Trends in SUD before the COVID-19 Pandemic

**Snapshot of Substance Use Problems in South Carolina:** Prior to the onset of the COVID-19 pandemic, the top problems related to substance use in South Carolina revolved around alcohol, cannabis, opioid/stimulants, and tobacco. Overall, in 2019, there were over 474,000 substance use disorder/dependence-related hospitalization discharges across the State, with alcohol misuse being the chief reported substance (S.C. Office of Revenue and Fiscal Affairs, 2019). As shown in the figure below, among primary/secondary substance use disorder/dependence hospitalization rates (per 100,000), alcohol misuse was substantially more reported (1,013.6 per 100,000) at approximately five times the rate of the next substance (cocaine at 236.7 per 100,000). Tobacco misuse has historically been reported in South Carolina almost exclusively as a secondary diagnosis for hospitalization in association with one of the substances in the figure below at a rate of approximately 80% (or higher in certain years).

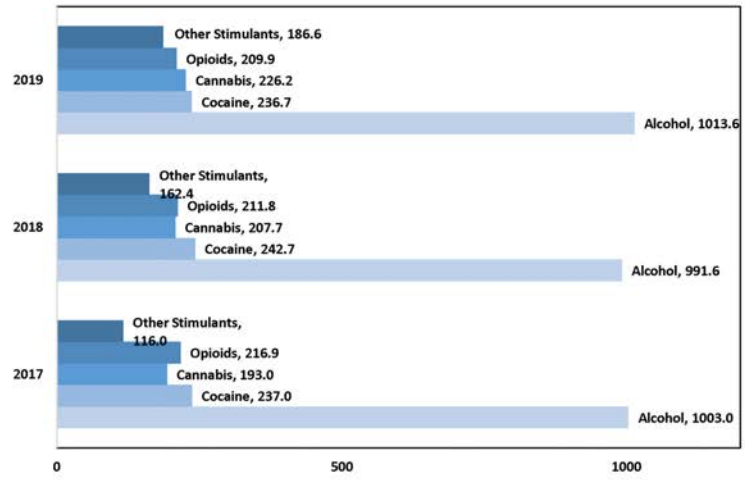



*Figure. Abuse/Dependence-related substance use hospitalization rates per 100,000 in South Carolina, 2017-2019*

In terms of alcohol consumption, the level of self-reported heavy drinking among South Carolina adults in the CDC's Behavioral Risk Factor Surveillance System (BRFSS) was on par with the national average (6.5%), while reporting slightly lower levels of binge drinking compared to the national average (15.1% vs.16.2%).

There is also a high burden of tobacco use in the State. South Carolina adults who reported as a current smoker in the BRFSS were higher than the national average (18.0% vs. 16.1%). However, South Carolina adults who reported e-cigarette use were slightly lower than the national average (4.1% vs. 4.6%). E-cigarette use is becoming a problem among youth, in that the percentage who self-reported as lifetime vaping use in 2018 was up to 24.7% (S.C. Communities That Care Survey, 2018).

Regarding prescription and illicit drug use in the State, the year-over-year increase in all drug mortality slowed over the past two years as total drug overdose deaths increased 3% from 1,103 in 2018 to 1,131 in 2019 (justplainkillers.com/data), a slower pace than the 10% increase the previous year and the 14% increase prior to that. In recent years, there has been a particularly sharp increase in year-over-year deaths involving fentanyl (17% increase from 460 in 2018 to 537 in 2019) and psychostimulants (40% increase from 242 in 2018 to 338 in 2019). In 2019, 10,809 substance use disorder/dependence-related hospitalizations occurred due to opioid use. Of those, 49.4% were females and 50.6% were males. Of those hospitalized, 82% were White, 16% Black, and 2% belonged to another race, with similar trends being seen for previous years.

In State Fiscal Year (SFY) 2019, over 30,600 South Carolinians were seen at a county alcohol and drug abuse authority for a substance use disorder (SUD). Over half (54.3%) of the patients at intake were diagnosed with an alcohol use disorder (AUD), while approximate one-third of patients were diagnosed with an opioid use disorder (OUD). Of all patients discharged during SFY 2019, 60% were male and 62% were White, and 33% were Black. The main referral source of patients was the criminal justice system (40% of total referrals), and approximately 10% of patients reported either active or prior injection use at intake. Overall, while there are more patients seen by county authorities in urban settings, there has been a continued uptick of patients being seen in more rural settings as access to care – as well as need for treatment – continues to increase in those areas.

## Impact of COVID-19 on SUD in South Carolina

**Increases in Alcohol and Other Drug Use:** For many South Carolinians, the COVID-19 pandemic is associated with significant levels of psychological distress linked to anxiety, fear, stress, isolation, and economic loss. Because people typically drink or use substances to alleviate negative feelings – or simply to feel "good" – we did see these factors exacerbate alcohol and other drug issues during 2020.

Although the increase in substance-related problems is difficult to quantify, the volume of calls to our agency's main telephone line (which is the point of connection from SAMHSA's National Helpline) increased 25%-35% with day-to-day variation from April through June 2020. Almost all calls were from family members or friends seeking services for someone in need of treatment for a substance use disorder.

Direct service providers and recovery community organizations (RCOs) reported an increasing number of stable patients and persons in recovery returning to substance use. One RCO began promoting the message that if someone made it through 2020 without returning to use, it should count as two years in recovery. This served as validation to their members that staying sober amidst COVID-19 stressors was especially challenging.

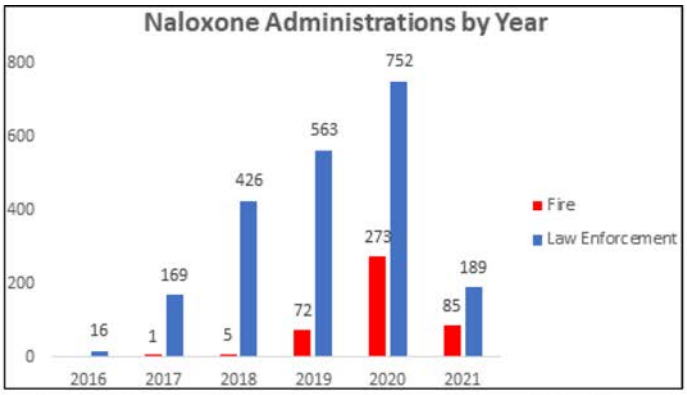
The S.C. Department of Revenue (SCDR), which oversees licensing of the State's alcohol wholesalers and retailers, provided figures to *The Charleston Post* and *Courier* indicating a 27% uptick in sales for the period of March 15 – June 30, 2020 when compared to the same timeframe in 2019.

In April 2020, we began seeing memes in social media and on the internet that set norms around and supported non-traditional behaviors and culture related to drinking during the COVID-19 pandemic. Memes depicting children's toys and dolls that were drinking, images and recipes for "quarantinis," memes supporting the acceptance of drinking earlier in the day, etc., led us to conclude that an increase in drinking was occurring. This trend also led us to believe that people who may not have otherwise experienced problematic drinking or an alcohol use disorder could be vulnerable to such issues. We surmised early on in the pandemic that we would probably see increased use of all substances that could result in long-term impacts and more individuals developing use disorders.

**Increase in Overdoses:** Like many States, 2020 hit South Carolina hard. As shown in the trend graph below, suspected opioid overdoses with EMS response were already slightly higher than 2019 at the start of the year, but that gap widened in March, during the COVID-19 pandemic, and May was the highest month in the State's history. While the climb flattened later in the year, overdose incidents have remained elevated. Suspected opioid overdoses reported by EMS were around 40%-50% higher in South Carolina in 2020 than in 2019. Overdose incidents continue to remain elevated into 2021, with suspected opioid overdoses in March 2021 estimated as 17% higher than in March 2020.


*Source: S.C. Department of Health and Environmental Control, Bureau of EMS and Trauma*

The Law Enforcement Officer Naloxone (LEON) and firefighters' Reducing Opioid Loss of Life (ROLL) programs had a record year. There were 752 law enforcement and 273 fire department Narcan® administrations reported, a 34% and 279% increase respectively in those programs over 2019. Naloxone administrations for these programs for Q1 2021 were 53% higher than Q1 2020 (100% higher in ROLL and 37% higher in LEON). Much of the increase in firefighter Narcan® administrations has been due to increased training and participation in this newer program.




*Source: S.C. Department of Health and Environmental Control, Bureau of EMS and Trauma*

Although total emergency department (ED) visits dipped in April and May of 2020, for drug overdoses, the total number and rate of ED visits spiked during this time period and remained elevated through September, the last month of publicly available data. These increased ED visits were driven primarily by opioids.

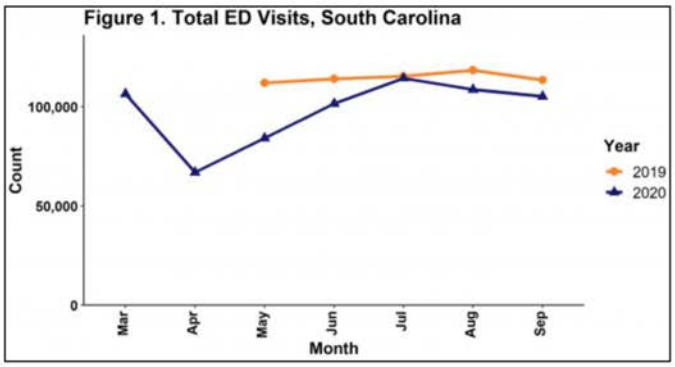
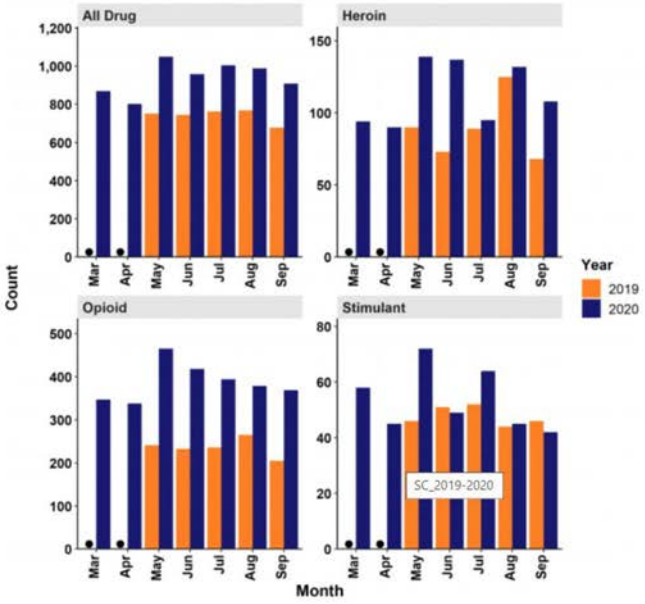


**Figure 2. Total ED Visits for Overdoses, by Drug Category, South Carolina**



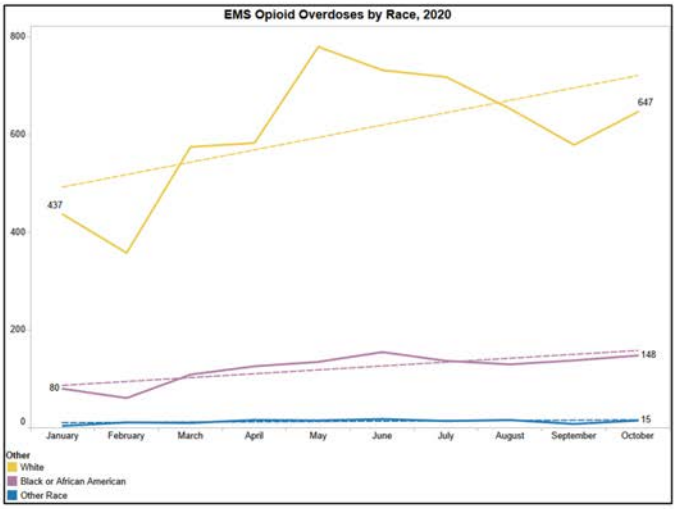

**Increase in Overdose Deaths:** Provisional mortality data from the CDC for South Carolina predicts 1,625 drug overdose deaths for the 12-month period ending in September 2020, a 45.3% increase over the 12-month period ending in September 2019. This is well above the national average increase of 28.8% percent and is the fifth-highest reported increase for this time period, behind the District of Columbia, Louisiana, Kentucky, and West Virginia.

Illicitly made synthetic opioids, which can include fentanyl, are largely responsible for this increase, with 62.4% of those predicted overdose deaths estimated to involve synthetic opioids. Preliminary data also suggests that deaths involving psychostimulants outpaced deaths involving prescription drugs in 2020. Final overdose fatality data for 2020 will be reported in the fall of this year.

We are still working on challenges related to real-time data and information that describes the types of substances present or related to mortality. Resources for toxicology testing vary by county in South Carolina, leading to delays and inconsistency in reporting. The State is working toward more participation in syndromic surveillance and building capacity to report substance-specific data. It is also more difficult to parse out specific types of drugs from some data sources like EMS response to overdoses.

During the pandemic, our public safety partners informed us of an increased number of seizures of illicit drugs being delivered by the U.S. Postal Service and parcel services. We saw new illicitly manufactured benzodiazepines being produced and trafficked in larger volumes in our State and bordering States. Finally, we are seeing an increase in other (non-opioid) prescribed substances, such as ketamine and gabapentinoids, associated with overdose and in the drug screens of patients receiving services, and in toxicology reports on overdose decedents. We believe that in time and with more data we may discover the impact of these substances during the pandemic.

**Demographic Trends of Interest:** We generally find disproportionate EMS response to opioid overdoses among individuals who are Whites, male, and aged 25-44. Black individuals have experienced increased opioid overdoses since the pandemic, although at a slower rate than Whites. However, the burden of opioid overdoses among Black individuals varies by county.




**data through Oct. 31, 2020.*

We also saw an impact not just in our urban areas, but in our rural communities. The counties with the highest number of total incidents were some of the more populated areas, but we saw a high burden for the rate of overdoses and percentage increase over the previous year in some of our more rural counties.

**Impact to Service Delivery Related to COVID:** Service provider organizations adapted quickly to ensure social distancing precautions could be taken while maintaining service availability. However, the ways in which they and their referral partners adapted did diminish some capacity to treat and reduced expected revenue for the year. Some direct effects and adaptations included:

- Referrals from partner organizations greatly diminished during the pandemic, including school-based referrals, (despite schools being open for in-person education), hospital referrals, and drug court referrals.
- Providers ceased or limited walk-in clinical assessments for services. To ensure distancing measures could be taken, they moved to appointment-only intake.
- Providers limited routine urine drug screens, which restricted knowledge of patient relapse.
- Despite use of telehealth, many patients in remote rural locations did not have adequate cellular or internet service access and were unable to join services virtually.
- In-person group psychotherapy dynamics and benefits were lost without group services.
- Inpatient care providers limited bedded services to allow for safe distancing and quarantine.

## Addressing COVID-19: Actions by the South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS)

**Prevention:**

"Pause" Campaign: DAODAS created and placed television and social media messaging that encouraged parents to take advantage of the fact that life had effectively "paused" to have conversations with their children about the dangers of prescription drugs during the month of May 2020. The campaign encouraged citizens to visit the agency's website for more information on conversation starters for age-appropriate talks with their children (kindergarten – college age) To view the spot on YouTube, visit https://www.youtube.com/watch?v=_IwQcEOAOnA

Alcohol Meme Campaign: Memes seeking to humorize increased alcohol consumption during quarantine began appearing on social media channels during the spring and early summer of 2020. In response to the "normalization" of alcohol use as a way of coping with the stress and "life curveballs" that were thrown at people during the pandemic, DAODAS worked with our advertising partner to create memes that were promoted on social media (Facebook, Instagram, and Twitter). By developing our own memes that played off the prevalent "pro-drinking" messages and turning the conversation instead to the dangers of drinking too much, too often, or at atypical times of day, we hoped that South Carolinians would take a moment to make sure they were not unintentionally harming themselves or others with altered drinking habits. The messages included a link to the Alcohol Use Disorders Identification Test (AUDIT) on the DAODAS website, a brief 10-question self-test that anyone can use to assess their own drinking behavior and obtain a recommendation as to whether they should seek assistance with changing that behavior. In addition to appearing on DAODAS social media pages, many local service providers and coalitions shared the content on their pages as well to boost the reach of the campaign. The campaign ran from June 15 through July 5, 2020.

"1, 2, Breathe" Narcan® Campaign: DAODAS recognized the negative impact of social isolation by monitoring the trends related to the increases in overdoses and Narcan® administration by first responders and EMS throughout 2020. In collaboration with its advertising partner, DAODAS developed the "1, 2 Breathe" campaign to demonstrate the

effectiveness, availability, and accessibility of Narcan®. Campaign materials developed and utilized at the State and local levels included banner ads, outdoor billboards, posters, print ads, brochures, social media content, fact sheets, palm cards, and television spots. Materials were utilized throughout the fall and winter at the local level, as well as at the State level. During the month of December, the television spot was aired on network television, social media channels (Snapchat, Instagram, and Facebook), and streaming services such as Sling TV, Discovery Network apps, Tubi, and AT&T/Direct TV Now.

Drive-Thru Events: Taking into account safety measures for staff and the public related to COVID-19, local agencies held drive-thru events to distribute information (fact sheets, brochures, palm cards, etc.) on a variety of substances (alcohol, tobacco/vaping, marijuana, prescription drugs, etc.). Many of these events also included distribution of Narcan®, as well as Deterra® packets for safe disposal of medications.

Food Pick-Up/Delivery Programs: Agencies worked to provide prevention information on a variety of substances (alcohol, tobacco/vaping, marijuana, prescription drugs, etc.) and Deterra® packets for safe disposal of medication to youth, families, and older adults via fact sheets, brochures, etc., through school lunch pick-up programs, food distribution programs for families, and Meals on Wheels delivery programs for the elderly.

Education Programs: Prevention staff adapted evidence-based programs, such as Strengthening Families, Botvin's Life Skills, and others, to deliver them virtually as schools made the transition to online learning in the spring of 2020. This type of delivery has continued for some areas though the fall of 2020 and spring of 2021. Several different types of online platforms have been used to connect with students and families based on the platforms used by the schools and faith communities that are helping to coordinate the services.

**Treatment:**
During the first week of March 2020, when we knew distancing measures would be taken, we worked closely with the Governor's COVID-19 Emergency Response Team and local partners to support access to and adaptation of treatment services with distancing precautions. For example, we:

- Facilitated a bi-weekly call for members of the State's Opioid Emergency Response Team to share situational updates as changes related to COVID-19 occurred in the illicit drug supply, healthcare practices, treatment and recovery operations, and prevention and intervention programs. Focusing on these priority areas proved helpful for awareness and for exchanging tips and guidance across sectors.
- Worked directly with State's opioid treatment programs (OTPs) providing methadone services to ensure that their emergency plans were operationalized. With approval of the DEA, we authorized 14-day and 28-day take-home doses of methadone for all of the nearly 7,000 patients in the State who were stable in treatment.
- Issued press releases and social media messaging regarding the availability of treatment services. Messages included information on where and how to access free assessments, and the locations of recovery services like mutual aid groups that had transitioned to online platforms.

- Supported telehealth service delivery with reimbursement from grant funding for crisis management, individual psychotherapy, peer support, case management, and other services delivered virtually or telephonically. We worked with our State Medicaid agency to educate them on the need to allow Medicaid reimbursement for the same services. We worked with our State Board of Medical Examiners for the approval of prescribers to initiate some medication-assisted treatment services via telehealth. With some of our State funds, we subsidized the broadband costs for smaller and rural provider organizations to guarantee their ability to connect to the State's telehealth network. We also allocated State funds for providers to purchase cellular phones, minutes, and data plans for use by patients in need of access. Positive results have been seen with telehealth services, including:
    - Retention of patients despite changes with office/clinic location closures.
    - Increased engagement of existing patients due to the elimination of typical challenges with transportation and childcare.
    - Clinical staff report that they are still able to see patients' social context and environment with virtual services at home.
    - Patients have reported high satisfaction with the tele-services and a desire to have it as an option along with in-person services moving forward.
- Partnered with the S.C. Department of Mental Health (SCDMH) to establish the SC HOPES Support Line – a toll-free line with 24/7 connection for callers to access licensed mental health and addictions counselors by phone. Services include access to Spanish language and hearing-impaired services. The SC HOPES program is intended for any South Carolinian experiencing a mental health or addiction concern – particularly as those issues relate to the isolation, uncertainty, and other strains brought on by the circumstances of COVID-19. Due to the quick action of the U.S. Department of Health and Human Services (HHS) – SAMHSA, in particular – we had the funds to market the SC HOPES line Statewide via television, social media, and billboards.

**Recovery:**
As job losses were suffered into April and May of 2020, we recognized a need to provide short-term rental assistance for some individuals living in our federal SAPT Block Grant-supported recovery housing. With approval from SAMHSA, we were able to redirect some State Opioid Response (SOR) Grant funds to ensure housing continuity for those individuals at risk of eviction.

**Overdose Reversal:**
Given concerns that the isolation associated with COVID-19 could increase rates of overdose, we worked with our State's Department of Health and Environmental Control (SCDHEC), the S.C. Law Enforcement Division, and the Atlanta/Carolinas High Intensity Drug Trafficking Area (HIDTA) staff to develop an Overdose Surveillance and Rapid Response Team. This State-level overdose surveillance and collaboration is designed to lead to local mobilization with a data-to-action communication framework.

As the team identifies geographical hot-spot areas, the members collectively determine how to respond, supporting targeted local strategies to prevent overdose death:

- Weekly data monitoring for suspected overdoses.
- Data-sharing agreement and action protocol across core multiagency group.
- Rapid alert and engagement of local officials and stakeholders.
- Synchronizing targeted response and resource deployment across sectors.

We have not definitively correlated these rapid-response efforts to reduction in overdose morbidity and mortality, particularly during the COVID-19 pandemic when activity has been heightened and the drug environment has been changing. However, these efforts may have had some impact. From a retrospective review of data and the action log, overdose incidents ranged anywhere from 20%-50% lower in the month following outreach from the rapid response team.

As soon as we knew isolation measures would be taken, we also facilitated vast naloxone distribution, anticipating that people would be at higher risk of overdose and needing to have naloxone stocked at home. We worked with the State's opioid treatment programs (OTPs) to have naloxone dispensed to patients receiving take-home methadone. We also shipped between 6,500 and 7,000 boxes of Narcan® to our community distributors, including recovery community organizations (RCOs) that engaged in distribution in a number of ways, such as contact-free pick-up and home drop-off of the overdose antidote.

## Addressing COVID-19: Actions by the Federal Government

**Investing in the Substance Abuse Prevention and Treatment (SAPT) Block Grant:** During the pandemic, Congress has made significant investments in the Substance Abuse Prevention and Treatment (SAPT) Block Grant to help ensure that individuals at risk for or struggling with addiction get the support that they need. We are grateful for the $1.65 billion in supplemental funding for the SAPT Block Grant in the December 2020 COVID-19 relief package. In addition to funding, this legislation afforded SAMHSA the ability to offer States flexibility in certain allowable uses of funds, timelines, and reporting requirements.

We are also appreciative of the $1.5 billion in supplemental funding for the SAPT Block Grant included in the American Rescue Plan of March 2021. The American Rescue Plan's supplemental funding for the SAPT Block Grant allows State alcohol and drug agencies until September 30, 2025, to expend these resources. This additional time to spend the funds is beneficial for a number of reasons:

- *Assists States with planning*: The role of State alcohol and drug agencies includes working to ensure an effective, efficient, and coordinated system of care across substance use disorder prevention, treatment, and recovery. One-time funding, while helpful, can create a fiscal cliff and generate uncertainty regarding future budgets. A multi-year investment helps States plan with consistency.
- *Promotes reliable support for providers*: State alcohol and drug agencies are supporting providers of prevention, treatment, and recovery programs and services. It is critical that providers remain assured that resources will be provided beyond a one-time allotment to allow them to hire staff or expand programs with confidence that resources will be maintained.

- *Maximizes efficiency by leveraging the current infrastructure*: The SAPT Block Grant represents an effective and efficient portal through which to direct resources for substance use disorder programs and services. States and providers are already well familiar with the protocols connected to this funding mechanism. This includes the application, data reporting requirements, and more.
- *Affords States flexibility to address local needs*: The SAPT Block Grant allows State alcohol and drug agencies to address their own unique needs related to prevention, treatment, and recovery. This flexibility is important given that each State faces different challenges.

**Virtual Initiation of Medication-Assisted Treatment (MAT):** Medication-assisted treatment (MAT) is the gold standard for the treatment of opioid use disorder. During the pandemic, the DEA, in coordination with SAMHSA, authorized practitioners to admit and treat new patients with an opioid use disorder (OUD) during the public health emergency. Specifically, on March 31, 2020, the DEA announced that during the COVID-19 public health emergency, practitioners may prescribe controlled substances – including buprenorphine, a medication used to treat OUDs – to patients using telemedicine without first conducting an in-person evaluation.

**Expanded Methadone Take-Homes:** Due to stay-at-home orders and social distancing requirements across the United States, individuals with an opioid use disorder faced increased barriers to accessing MAT at the beginning of the pandemic. On March 16, 2020, SAMHSA released guidance offering flexibility to States so that all stable patients in an opioid treatment program (OTP) could receive 28 days of take-home doses of the patient's medication. Additionally, the State may request up to 14 days of take-home medication for those patients who are newer or less stable but whom the OTP believes can safely handle this level of take-home medication.

**Ability to Purchase Personal Protective Equipment (PPE) for Substance Use Disorder Providers:** While many patients and providers have increasingly utilized telehealth services during the pandemic, in-person services are still critical. Face-to-face interactions may be unavoidable, or may be preferred by patient. On May 7, 2020, SAMHSA announced that because of the nature of standard SUD service delivery, the agency's discretionary grant funds may be used to purchase personal protective equipment (PPE). This has helped ensure the safety and wellbeing of frontline SUD providers.

## Recommendations

I offer the following recommendations for the Committee's consideration.

**Route Federal Resources for Substance Use Disorder Services Through the State Alcohol and Drug Agency:** It is crucial that federal grants for substance use disorder service delivery are routed through the State alcohol and drug agency to ensure a coordinated, efficient, high-quality substance use disorder service delivery system. State alcohol and drug agencies play a critical role in overseeing and implementing a coordinated prevention, treatment, and recovery service delivery system. As indicated earlier, these agencies develop annual Statewide plans to ensure an efficient and comprehensive system across the continuum. Further, State alcohol and drug agencies promote effective systems through oversight and accountability.

NASADAD members promote and ensure quality through standards of care, technical assistance to providers, and other tools. As a result, NASADAD strongly recommends that federal funding, programs, and policies designed to address substance use prevention, treatment, and recovery flow through the State alcohol and drug agency. This approach allows federal initiatives to enhance and improve State systems and promotes an effective and efficient approach to service delivery. Federal policies and programs that do not flow through or at least coordinate with the State agency run the risk of creating parallel, duplicative, or even contradictory publicly funded systems and approaches.

**Gradually Transition Over Time from Opioid-Specific Resources to Investing Funds in the SAPT Block Grant:** While we are incredibly grateful for opioid-specific grants to State alcohol and drug agencies, such as the State Targeted Response (STR) and State Opioid Response (SOR) grants, States would benefit from more flexibility to address all substances of concern. As a result, we recommend a gradual transition that would allocate a portion of SOR dollars to the SAPT Block Grant starting in FY 2022. In addition, we hope Congress resists adding additional substances to SOR's allowable use of funds. Adding alcohol, for example, to the list of allowable use of funds under SOR would have the effect of creating two separate Block Grants designed to address substance use disorders. This approach is inefficient and does not promote a coordinated approach to resource delivery.

**Maintain Recent Flexibilities to Ensure Access to Substance Use Disorder Services:** The regulatory changes seeking to ensure continued substance use disorder service delivery during the pandemic should be maintained at least one year after the federal government determines the United States is no longer operating under a public health emergency. At this point, these policies should be further evaluated. These actions include the flexibilities referenced earlier regarding take-home doses of methadone for certain patients; the ability to initiate buprenorphine treatment for opioid use disorders without a face-to- face appointment; reasonable flexibilities related to HIPAA rules in order to allow service providers to utilize a variety of communication tools for service delivery; and others.

**Invest in technology and broadband to make telehealth substance use disorder services more accessible**: We hope Congress considers investments in the tools that allow telehealth services to move forward. These tools include hardware, software, and broadband capabilities. As referenced earlier in my testimony, many families in rural and underserved communities simply do not have access to these tools and therefore they do not have access to lifesaving telehealth services.

**Continue Support for Workforce Development Including Prevention Workforce Proposal in CARA 3.0**: We appreciate the variety of workforce programs supporting recruitment, retention and development of substance use professionals. We appreciate, for example, the Minority Fellowship Program (MFP) managed by SAMHSA.

We also draw attention to Section 211 of S. 987, The Comprehensive Addiction and Recovery Act (CARA) 3.0. Section 211 of this proposal would create a grant program within SAMHSA that would address a large unmet need: supporting our nation's primary prevention workforce. In particular, the grant program would help State alcohol and drug agencies (1) support recruitment, professional development, and training to ensure diversity, equity, and inclusion in the substance use disorder prevention workforce, (2) enhance or establish initiatives related to credentialing or other certification processes for prevention, (3) partner with elementary schools,

middle schools, high schools, or institutions of higher education to generate interest in careers in substance use disorder prevention, and more. We applaud Senators Whitehouse, Portman, Capito, Klobuchar, Shaheen, and Cantwell for their work to introduce CARA 3.0 given this provision and others related to substance use disorders.

**Bolster the Role of the Substance Abuse and Mental Health Services Administration (SAMHSA):** We support maintaining investments in SAMHSA as the lead agency within HHS focused on substance use disorders. The nation benefits from a strong SAMHSA given the agency's longstanding leadership in the field. SAMHSA should be the default home of substance use disorder discretionary grants and related programming. NASADAD appreciates the role the Assistant Secretary for Mental Health and Substance Use plays in coordinating work across HHS to promote a unified federal approach to substance use disorders. We are particularly grateful for the leadership of the current Acting Assistant Secretary, Tom Coderre. In addition, we applaud President Biden's choice to nominate Dr. Miriam Delphin-Rittmon, State director in Connecticut, as the next leader of SAMHSA. We strongly support Dr. Delphin-Rittmon as the next Assistant Secretary for Mental Health and Substance Use and hope this Committee will take action to consider her nomination as soon as possible.

**Maintain a Strong White House Office of National Drug Control Policy (ONDCP):** ONDCP plays an important role in coordinating drug policy across the federal government. ONDCP's annual National Drug Control Strategy represents an important tool to set priorities, coordinate policy across all parts of the federal government, and evaluate the implementation of the Strategy. NASADAD believes that federal investments should be made to ensure ONDCP is adequately staffed to fulfill its mission. We are appreciative of the leadership of Regina LaBelle, current Acting Director of ONDCP.

[SUMMARY STATEMENT OF SARA GOLDSBY]

**Impact of COVID–19 on substance use disorders (SUD)**: The pandemic has had a significant impact on the substance use disorder system in South Carolina. From April-June 2020, the S.C. Department of Alcohol and Other Drug Abuse Services (DAODAS) experienced a 25 percent–35 percent increase in call volume, primarily from family and friends seeking services for someone in need of treatment. Additionally, providers and recovery community organizations (RCOs) reported an increasing number of stable patients and persons in recovery returning to substance use. Suspected overdoses were 40 percent–50 percent higher in South Carolina in 2020 than in 2019, and provisional data predicts a 45.3 percent increase in drug overdose deaths for the 12-month period ending in September 2020 compared to the previous year.

**Past-year actions by the S.C. Department of Alcohol and Other Drug Abuse Services (DAODAS)**:

- *"Pause" Campaign*: Shared television and social media messaging that encouraged parents to take advantage of the fact that life had effectively "paused" to have conversations with their children about the dangers of prescription drugs.
- *Naloxone distribution*: Shipped over 6,500 boxes of Narcan® to community distributors, and helped ensure that individuals with methadone take-homes had naloxone on hand.
- *"1, 2, Breathe" Narcan® Campaign*: Developed the "1, 2, Breathe" campaign to demonstrate the effectiveness, availability, and accessibility of Narcan®.
- *Innovative prevention outreach*: Through school lunch pick-up programs, food distribution programs, and drive-thru events, local agencies distributed educational materials on substance use.
- *Education Programs*: Prevention staff adapted evidence-based programs to deliver them virtually.
- *Worked with opioid treatment programs (OTPs)* providing methadone services to ensure that their emergency plans were operationalized.
- *Issued press releases and social media messaging* regarding the availability of treatment services.
- *Supported telehealth service delivery* for crisis management, individual psychotherapy, peer support, case management, and other services delivered either virtually or telephonically.
- *Established the SC HOPES Support Line*, a toll-free line with 24/7 connection for callers to access licensed mental health and addictions counselors by phone.
- *Housing for those with SUDs*: Utilized Federal funds to ensure housing continuity for individuals at risk of eviction.

**Recommendations**:

- *Route Federal resources for SUD services through the state alcohol and drug agencies* to ensure a coordinated, efficient, high-quality substance use disorder service delivery system.
- *Gradually transition from opioid-specific resources to the SAPT Block Grant* to give states more flexibility to address all substances of concern. Avoid adding other substances to SOR's list of allowable use of funds to promote the transition to the SAPT Block Grant for maximum efficiency.
- *Maintain SUD-related flexibilities* at least 1 year after the public health emergency to further evaluate their impact.
- *Invest in technology and broadband* to make telehealth SUD services more accessible.
- *Continue support for workforce development*, including prevention workforce proposal in CARA 3.0 (Sec. 211).
- *Bolster the role of the Substance Abuse and Mental Health Services Administration (SAMHSA)* as the lead Federal agency for SUD issues.
- *Maintain a Strong White House Office of National Drug Control Policy (ONDCP)*.

The CHAIR. Thank you, Dr. Goldsby.
We will turn to Dr. Keller.

**STATEMENT OF ANDY KELLER, PH.D., PRESIDENT AND CEO & LINDA PERRYMAN EVANS PRESIDENTIAL CHAIR, MEADOWS MENTAL HEALTH POLICY INSTITUTE, DALLAS, TX**

Dr. KELLER. Good morning, Chair Murray, Ranking Member Burr, and Members of the HELP Committee. Thank you for the opportunity to testify today. My name is Andy Keller, and I lead the Meadows Mental Health Policy Institute, a Texas non-profit committed to helping Texas and the Nation improve the availability and quality of evidence-driven mental health and substance use care through non-partisan, data-driven, and equitable policy and program guidance.

For over a decade prior to the pandemic, every leading indicator related to the pre-existing mental health and addiction epidemics were worsening. Deaths from suicide, overdose, and comorbid health conditions driven by mental illness and addiction were at 20-year highs.

This long-standing epidemic was made worse by systemic inequities for Black, indigenous, and other people of color whose access to care was inequitably impeded by barriers of language, culture, mistrust, and geographic proximity, in neighborhoods where the jail or detention center was too often closer than any clinic or hospital.

The pandemic has made all of this worse, as Chair Murray described so well. Rates of death from overdose rose 33 percent in 1 year nationally, approaching 90,000 lost, the highest number ever recorded.

Indicators of depression increased four-fold, and the number of people seriously considering suicide doubled.

Mental illness is the second leading driver of COVID–19-related deaths, following only age. And, the effects of COVID–19 worsen underlying inequities, taking the lives of four times as many working-age Latino Texans, and leaving nearly 50 percent more Black children without a parent because of COVID–19 than other children.

What is more, these effects will not end as the pandemic recedes. They will increase in the months and years ahead, which we have seen from other disasters.

Senators, I have one main lesson to share with you today that COVID–19 taught us, and that is that if America pairs the will to act with the necessary resources, our health systems and researchers can defeat a novel disease by rapidly scaling and delivering early detection, treatment, and prevention.

With the will and resources, we can do the same for mental illness and addiction. In fact, it will actually be easier to do for mental illness and addiction because we already know how to successfully detect and treat these conditions.

At Meadows, we have modeled the universal access to just two evidence-based treatments that could save almost 40,000 lives a year from suicide and overdose. This is the same approach we used to turn the tide on heart disease and cancer over the last generation.

In 1976, my grandfather died of a heart attack but was resuscitated at Memorial Hospital in Yakima and sent home then to begin his treatment with cholesterol-lowering diet and medication. Twenty years later, I began my—that same treatment. Decades before, any sort of risk like that for my heart disease in primary care, and likely will never suffer such a crisis that my grandfather did. Contrast this to the 20 years I waited to receive a diagnosis and successful treatment for my anxiety disorder.

We made the shift from crisis-based care for heart disease and cancer in a generation, and we did the same for COVID–19 in less than a year. Now, we need to make the same commitment of will and resources to universally detect, treat, and recover from mental illness and addiction.

Last year, the Meadows Institute joined with 14 leading mental health and addiction policy organizations to release a unified vision for doing just that. And, over the last year, we have made remarkable progress in Texas, scaling many of these approaches.

We focus first on children. Mental illnesses are pediatric illnesses. And, in 2020, Texas' 12 publicly funded medical schools used $100 million to scale up universal access to child psychiatry consultation in primary care, and urgent access to psychiatric health, telehealth, in Texas schools, achieving statewide reach in less than a year, engaging almost 5,000 primary care providers and hundreds of schools educating two million of our five million students.

Previous COVID–19 relief bills and the American Rescue Plan funded similar efforts, but the scope of the psychiatry access program expansion nationally is less than what we fund in Texas alone, and the school-based efforts lacked concrete strategies leveraging telehealth.

We are also scaling care in Texas for suicide and depression through grant programs to overcome startup costs for measurement-based care and collaborative care, and hundreds of primary care providers in North Texas, or the Cloudbreak Initiative, in partnership with UT Southwestern.

Congress can create similar momentum nationwide providing grants to health systems and primary care practices to cover startup costs, plus technical assistance, to be sure they set it up the right way to qualify for ongoing reimbursement.

In early 2021, both RAND and the Bipartisan Policy Center made recommendations similar to this and it is fully aligned with the evidence-based practice components of the national response to COVID.

It would also be useful to eliminate copays for collaborative care and Medicare, Medicaid, and commercial coverage.

For more severe disorders, which have been severely impacted by COVID–19, the coordinated specialty care set aside in the Federal Mental Health Block Grant has been extremely helpful and should be expanded.

It should also—we should also require Medicare, Medicaid, and commercial payor coverage for coordinated specialty care, which is the benchmark treatment for psychosis.

We have also witnessed in the last year the tragic consequences that come from over-reliance on police response to mental health,

and we need to add 911 reform to the work of expanding 988 access and crisis care.

Equity, workforce, and telehealth also have to be addressed.

But, the main lesson is that in less than a year, we showed the world that we can learn how to detect, treat, and prevent a novel disease we had never seen before. We can do the same for mental illness and addiction with that same will and commitment of resources.

I am deeply grateful to the Committee for the opportunity to share this information about our experience in Texas, and I am happy to respond to your questions.

[The prepared statement of Dr. Keller follows:]

PREPARED STATEMENT OF ANDY KELLER

Chair Murray, Ranking Member Burr, and Members of the Senate Health, Education, Labor, and Pensions Committee, thank you for the opportunity to testify today regarding lessons learned over the last year as we responded to long-standing, inequitable, and steadily worsening epidemics of mental illness and substance use made dramatically worse by the COVID-19 pandemic. My name is Andy Keller, and I lead the Meadows Mental Health Policy Institute (Meadows Institute), a Texas-based non-profit policy research institute committed to helping Texas and the nation improve the availability and quality of evidence-driven mental health and substance use care. The Meadows Institute provides independent, nonpartisan, data-driven, and trusted policy and program guidance that creates systemic and equitable changes so all Texans can obtain effective, efficient behavioral health care when and where they need it. We are committed to helping Texas become a national leader in treatment for all people suffering from mental illness and addiction. More information about our work and history can be found on our website.[1]

**The COVID-19 Pandemic Has Made a Pre-Existing Epidemic Worse**

For over a decade prior to the COVID-19 pandemic, every leading indicator related to mental health and addiction was worsening:

- After increasing by over one-third across two decades, suicide rates paused overall in 2019, but continued to worsen for Black, indigenous, and other people of color.[2] Suicide is now the 4th leading cause of life years lost (after heart disease, lung cancer, and driving) and 2nd leading driver of disability.[3]
- After two years of slight improvement, overdose deaths continued an inexorable rise.[4]
- Poorly treated mental illness is the primary driver of suffering and costs from comorbid conditions, including diabetes, hypertension, infectious disease, and heart disease.[5]
- These factors were exacerbated by inequity for Black, indigenous, and other people of color, who generally receive less culturally responsive care and disproportionately end treatment prematurely, as their access to care is too often frustrated by barriers of language, culture, well-founded mistrust, inaccessibility, and geographic proximity in

[1] The Meadows Institute website can be viewed here: https://mmhpi.org; our latest policy work here: https://mmhpi.org/work/policy-updates/; and our history here: https://mmhpi.org/about/story-mission/

[2] Stone, D. M., Jones, C. M., & Mack, K. A. (2021). Changes in Suicide Rates—United States, 2018–2019. *MMWR. Morbidity and Mortality Weekly Report*, *70*. https://doi.org/10.15585/mmwr.mm7008a1

[3] The US Burden of Disease Collaborators. (2018). The State of US Health, 1990-2016: Burden of Diseases, Injuries, and Risk Factors Among US States. *JAMA*, *319*(14), 1444. https://doi.org/10.1001/jama.2018.0158

[4] Hedegaard, H., Miniño, A. M., & Warner, M. (2020). *Drug Overdose Deaths in the United States, 1999–2019. National Center for Health Statistics*. https://www.cdc.gov/nchs/products/databriefs/db394.htm

[5] Davenport, S., Gray, T. J., & Melek, S. (2020). *How do individuals with behavioral health conditions contribute to physical and total healthcare spending?* Milliman. https://www.milliman.com/-/media/milliman/pdfs/articles/milliman-high-cost-patient-study-2020.ashx

neighborhoods where the jail or detention center is closer than any clinic or hospital.[6] And the burden of racism adds yet another insidious and toxic stress that increases risks of poor health for a range of health outcomes, including mental illness and addiction.[7]

The pandemic has substantially worsened this pre-existing epidemic:

- Rates of death from overdose jumped in one year by 33%, especially deaths attributable to fentanyl and methamphetamine.[8]
- While rates of death from suicide are still being sorted (and may have dropped slightly),[9] underlying indicators of depression have increased four-fold during the pandemic, affecting one-quarter of Americans,[10] the number of people seriously considering suicide doubled,[11] and emergency department visits for mental health needs by youth have increased by one-third.[12]
- In line with long-standing trends of increased risk for co-morbid illness, people with mental illness were over 65% more likely to contract COVID-19,[13] and mental illness is the second leading driver of COVID-19 based mortality (after age).[14]

And the effects of COVID-19 worsened underlying inequities. Throughout the pandemic, Black (48%) and Latino (46%) adults have been more likely to report symptoms of anxiety and

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[7] Paradies, Y., Ben, J., Denson, N., Elias, A., Priest, N., Pieterse, A., Gupta, A., Kelaher, M., & Gee, G. (2015). Racism as a Determinant of Health: A Systematic Review and Meta-Analysis. *PLOS ONE*, *10*(9), e0138511. https://doi.org/10.1371/journal.pone.0138511

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[9] Ahmad, F. B., Cisewski, J. A., Miniño, A., & Anderson, R. N. (2021). Provisional Mortality Data—United States, 2020. *MMWR. Morbidity and Mortality Weekly Report*, *70*. https://doi.org/10.15585/mmwr.mm7014e1

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[13] Taquet, M., Luciano, S., Geddes, J. R., & Harrison, P. J. (2021). Bidirectional associations between COVID-19 and psychiatric disorder: Retrospective cohort studies of 62 354 COVID-19 cases in the USA. *The Lancet Psychiatry*, *8*(2), 130–140. https://doi.org/10.1016/S2215-0366(20)30462-4

[14] Nemani, K., Li, C., Olfson, M., Blessing, E. M., Razavian, N., Chen, J., Petkova, E., & Goff, D. C. (2021). Association of Psychiatric Disorders With Mortality Among Patients With COVID-19. *JAMA Psychiatry*, *78*(4), 380–386. https://doi.org/10.1001/jamapsychiatry.2020.4442

depression than white adults (41%),[15] and people of color have also disproportionately shouldered the burden of negative financial impacts.[16, 17, 18] Additionally, grief is a primary driver of mental illness,[19, 20, 21] and the pandemic has taken four times as many working age Latino Texans,[22] and nearly 50% more Black children have lost a parent to COVID-19 than other children.[23]

### Detection, Early Treatment, and Prevention Turned the COVID-19 Tide

Success against any disease depends on these three factors – detection as early as possible, evidence-driven treatment as early as possible, and prevention – and in under a year, United States researchers and health systems learned to do all three well against COVID-19. We had previously used these approaches to make historic gains for other diseases, including heart disease and cancer. We have yet to do this for mental illness and addiction.

Today in Texas and across the United States more broadly, we do not detect and treat mental illness – to the extent we detect and treat it at all – until eight to ten years after symptoms emerge.[24] Instead, we wait until suffering becomes obvious to the person (or the people around them), too often in the form of a crisis that leads to an emergency room, hospital, or –

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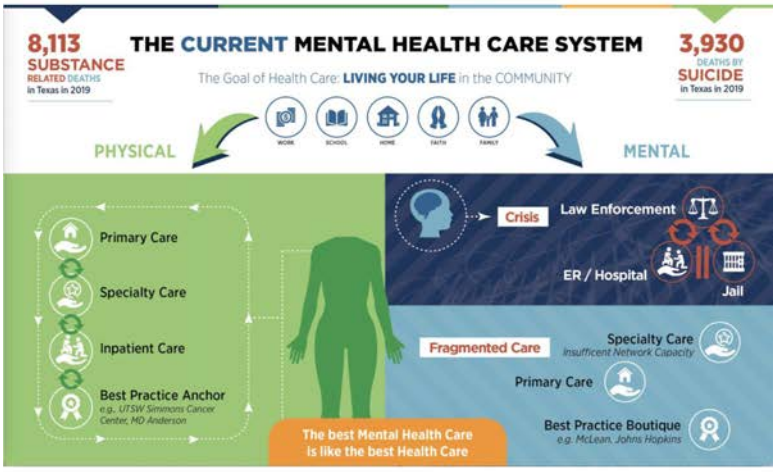
[22] *COVID's 'untold story': Texas Blacks and Latinos are dying in the prime of their lives*. (2020, December 19). Dallas News. https://www.dallasnews.com/news/2020/12/19/covids-untold-story-texas-blacks-and-latinos-are-dying-in-the-prime-of-their-lives/

[23] Kidman, R., Margolis, R., Smith-Greenaway, E., & Verdery, A. M. (2021). Estimates and Projections of COVID-19 and Parental Death in the US. *JAMA Pediatrics*. https://doi.org/10.1001/jamapediatrics.2021.0161

[24] American Academy of Child & Adolescent Psychiatry. (2012). *Best Principles for Integration of Child Psychiatry into the Pediatric Health Home*. https://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/systems_of_care/best_principles_for_integration_of_child_psychiatry_into_the_pediatric_health_home_2012.pdf

particularly for Black, Indigenous, and other people of color and people in poverty – a criminal justice setting. To focus in on just one major mental illness, depression, less than 1 in 15 of the over 1.5 million Texans suffering from depression each year receive the care needed to achieve symptom remission, and nearly 4,000 die annually from suicide, even though efficacy rates for available depression treatments are over 60%.[25]




**Detection, Treatment, and Prevention Also Work for Mental Illness and Addiction**

The primary lesson that needs to be learned from the COVID-19 pandemic is that the nation can rapidly scale up and deliver early detection, treatment, and prevention if we pair the will to act with the necessary resources. Fortunately, this would be much easier to do for mental illness and addiction, because we already know how to successfully detect and treat most of these conditions. At the Meadows Institute, we have modeled that universal access to just two evidence-based treatments – the Collaborative Care Model (CoCM) for depression and Medication-Assisted Treatment (MAT) for addiction – could save almost 40,000 lives a year from suicide (14,500) and overdose (24,000).[26]

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[25] Pence, B. W., O'Donnell, J. K., & Gaynes, B. N. (2012). The Depression Treatment Cascade in Primary Care: A Public Health Perspective. *Current Psychiatry Reports*, *14*(4), 328–335. https://doi.org/10.1007/s11920-012-0274-y

[26] Meadows Mental Health Policy Institute. (2020). COVID-19 Briefing: Modeling the Effects of Collaborative Care and Medication-Assisted Treatment to Prevent COVID-Related Suicide and Overdose Deaths. https://mmhpi.org/wp-content/uploads/2020/09/COVID-MHSUDPrevention.pdf

In addition to COVID-19, American researchers and health care systems have successfully turned the tide on heart disease and cancer using the same approaches. Until the 1980s, we identified heart disease primarily when a person had a heart attack, and we began treatment then, after the heart was damaged, to resuscitate the person and prevent a recurrence. We also used to wait to detect cancer until it resulted in functional impairment – a broken bone, coughing up blood – with devastating consequences and higher mortality rates. Today, we have systems in place in primary care and the community that detect most heart disease and many cancers much earlier, when they are easier to treat successfully, much less likely to be disabling and burdensome to the person receiving care, and less costly to society.

### A Unified Vision to Move Forward: Currently Being Scaled in Texas

Early on in the pandemic, the Meadows Institute joined a group of 14 of the nation's leading mental health policy and advocacy organizations to pull together a ***Unified Vision for Transforming Mental Health and Substance Use Care*** that we released in late 2020. This unprecedented collaboration unified America's two leading provider associations (the American Psychiatric Association and American Psychological Association), leading associations for community-based care (National Council for Behavioral Health) and inpatient care (National Association for Behavioral Health), the nation's largest grassroots advocacy groups (National Alliance for Mental Illness and Mental Health America) and leading policy advocacy groups (The Kennedy Forum, Treatment Advocacy Center, and Wellbeing Trust), and top regional policy leaders like the Meadows Institute (Massachusetts Association for Mental Health, One Mind, Peg's Foundation, and the Steinberg Institute) to design a road map to inform rapid scaling of detection, treatment, and prevention for mental illness and addiction.[27]

Below I briefly summarize how four of the seven pillars of this road map – Early Intervention, Emergency Crisis Response, Equity, and Workforce – are being rapidly scaled today in Texas. I also highlight federal efforts that can catalyze the will and resources needed to accelerate scaling in Texas and nationally to turn the tide on mental illness and addiction, just as we have for COVID-19 in the last year, and heart disease and cancer over the prior two decades.

### Early Intervention and Prevention

**For Children and Youth.** Mental illnesses are primarily pediatric illnesses, with half of all cases manifesting by age 14 and three-quarters by the time the brain stops developing in our mid-

[27] American Psychiatric Association, American Psychological Association, The Kennedy Forum, Massachusetts Association for Mental Health, Meadows Mental Health Policy Institute, Mental Health America, National Alliance on Mental Illness, National Association for Behavioral Healthcare, National Council for Behavioral Health, One Mind, Pegs Foundation, Steinberg Institute, Treatment Advocacy Center, & Well Being Trust. (2020). *A Unified Vision for Transforming Mental Health and Substance Use Care*. https://mmhpi.org/wp-content/uploads/2020/12/UnifiedVision2020.pdf

twenties.[28, 29] The key therefore is to deploy screening, detection, and early intervention in the two places where America is best able to help children – the family doctor and the local school.

We are scaling these solutions today in Texas. In mid-2019, the Texas Legislature overwhelmingly approved and Governor Abbott signed into law Senate Bill 11, which brought together the state's 12 publicly-funded medical schools to form the Texas Child Mental Health Care Consortium (TCMHCC). It was funded with an initial $100 million to provide universal access to child psychiatry consultation in primary care through a Child Psychiatry Access Network (CPAN), urgent access to psychiatric telehealth care and referrals in Texas schools through the Texas Child Health Access Through Telemedicine (TCHATT) program, and broad expansion of workforce training and the public psychiatry workforce more broadly.[30]

The Executive Committee of TCMHCC developed its implementation plan pre-pandemic[31] and launched on time despite the pandemic in May 2020. Since then, the TCMHCC has:

- Engaged nearly 5,000 pediatric primary care providers in the CPAN program, and
- Expanded TCHATT access to over 1.35 million Texas students (soon to reach 2 million), with thousands served, including 12.5% Black and 34% Latino students – numbers proportionate to the broader child population of Texas.

We are also working closely with the Texas Education Agency (TEA) to create guidance and supports for local school districts to implement systemic supports to ensure that local education agencies can provide a Multi-Tiered System of Supports, leveraging within an Interconnected School Framework.[32] The JED Foundation has also released updated guidance for these system-level supports.[33]

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[28] Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593–602. https://doi.org/10.1001/archpsyc.62.6.593

[29] Kim-Cohen, J., Caspi, A., Moffitt, T. E., Harrington, H., Milne, B. J., & Poulton, R. (2003). Prior juvenile diagnoses in adults with mental disorder: Developmental follow-back of a prospective-longitudinal cohort. *Archives of General Psychiatry*, *60*(7), 709–717. https://doi.org/10.1001/archpsyc.60.7.709

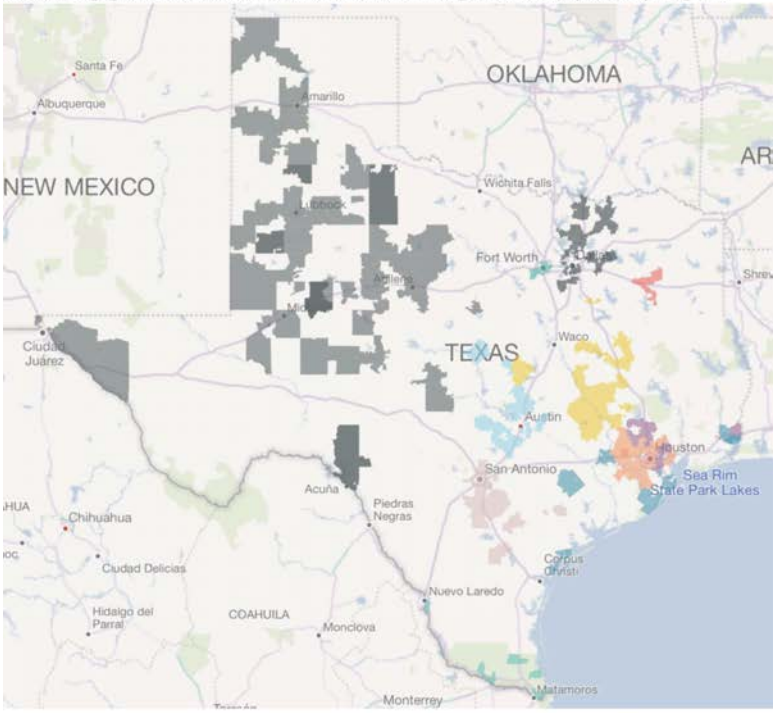
[30] You can read more about all of these programs at https://tcmhcc.utsystem.edu.

[31] See https://www.utsystem.edu/pophealth/tcmhcc/assets/files/resources/TCMHCC-Report%20to-the-LBB.pdf.

[32] For more information, see: https://mmhpi.org/wp-content/uploads/2019/10/RoadmapAndToolkitForSchools.pdf

[33] For more information, see: https://www.jedfoundation.org/wp-content/uploads/2021/02/The-Comprehensive-Approach-to-Mental-Health-Promotion-and-Suicide-Prevention-for-High-Schools_JED.pdf

**Schools Engaged in the Texas Child Health Access Through Telehealth (TCHATT) Program**




Previous COVID-19 relief bills and the American Rescue Plan expanded funding for psychiatry access programs like CPAN and school-based mental health supports, but the scope of the psychiatry access expansion nationally is less than what we have funded in Texas alone and the school-based efforts lack guidance on infrastructure development initiatives such as TCHATT.

**Recommendations**

Congress should scale funding for psychiatry access programs commensurate with the national need, in partnership with states, and should encourage use of telehealth in school-based mental health and substance use disorder services expansion. Systemic supports such as those we are helping TEA implement in Texas and those promoted nationally by the JED Foundation should also be incorporated into school-based efforts.

Congress should also make regulatory relief on telehealth permanent, just as states such as Texas are poised to do with overwhelming bipartisan support.[34]

**Suicide and Depression.** We are also scaling measurement-based care (MBC) and the Collaborative Care Model (CoCM) in primary care practices across Texas, beginning in North Texas. In 2018 we developed The Cloudbreak Initiative[35] in partnership with the UT Southwestern O'Donnell Brain Institute's Center for Depression Research and Clinical Care. The Cloudbreak Initiative is scaling detection and treatment in primary care across the region's health systems using two proven approaches: **Measurement-Based Care (MBC)**, the systematic use of repeated, validated measures to track symptoms and functional outcomes in clinical settings,[36] and the **Collaborative Care Model (CoCM)**, an approach to the treatment of depression pioneered by the AIMS Center at the University of Washington and refined over the last three decades that involves the integration of care managers and consultant psychiatrists directly within primary care settings to provide care that can help over 40% of people treated in primary care achieve full remission and another 25% achieve substantial relief. CoCM is well-established with over 80 randomized control trials documenting its efficacy, and its ability to improve health outcomes overall has been proven to bend the cost curve with a six-to-one cost savings primarily derived by improvements in co-morbid diseases that depression worsens, like diabetes and hypertension.[37] Improved outcomes for opioid-use disorders have also been demonstrated.[38] Cloudbreak is underway now, supporting in North Texas through scaling grants and technical assistance with the Methodist Health System and Baylor Scott & White Health. We are on track to help the region's 12 major health systems commit to achieving universal depression care within the next four years. Just as importantly, Cloudbreak is based on an

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[34] For more information on Texas House Bill 4 (Price – Amarillo), please see: https://www.statesman.com/story/news/politics/state/2021/04/14/texas-house-tentatively-approves-telehealth-drug-savings-bills/7221081002/

[35] Read more about Cloudbreak here: https://mmhpi.org/the-cloudbreak-initiative/

[36] On its own, MBC has been shown to improve patient outcomes by 40 to 60%. See Alter, C. L., Mathias, A., Zahniser, J., Shah, S., Schoenbaum, M., Harbin, H. T., McLaughlin, R., & Sieger-Walls, J. (2021). *Measurement-Based Care in the Treatment of Mental Health and Substance Use Disorders*. Dallas, TX: Meadows Mental Health Policy Institute. https://mmhpi.org/wp-content/uploads/2021/03/MBC_Report_Final.pdf

[37] Carlo, A. D., Barnett, B. S., & Unützer, J. (2021). Harnessing Collaborative Care to Meet Mental Health Demands in the Era of COVID-19. *JAMA Psychiatry*, *78*(4), 355. https://doi.org/10.1001/jamapsychiatry.2020.3216

[38] Olfson, M., Zhang, V., Schoenbaum, M., & King, M. (2020). Buprenorphine Treatment by Primary Care Providers, Psychiatrists, Addiction Specialists, And Others. *Health Affairs*, *39*(6), 984-992. https://doi.org/10.1377/hlthaff.2019.01622

LaBelle, C. T., Han, S. C., Bergeron, A., & Samet, J. H. (2016). Office-Based Opioid Treatment with Buprenorphine (OBOT-B): Statewide Implementation of the Massachusetts Collaborative Care Model in Community Health Centers. *Journal of Substance Abuse Treatment*, *60*, 6–13. https://doi.org/10.1016/j.jsat.2015.06.010

approach (CoCM) proven to work just as well for Black, Latino, and other communities of color.[39]

CoCM is also the only evidence-based medical procedure currently reimbursable in primary care, including by Medicare, nearly all commercial payers,[40] and an increasing number of Medicaid programs (including hopefully Texas by next month). Leading employer and private sector purchasing groups are also calling for its expansion.[41] The potential cost-savings of wide-spread implementation are considerable: a pivotal 2013 study found Medicare and Medicaid savings of up to six-to-one in total medical costs and estimated $15 billion in Medicaid savings if only 20% of beneficiaries with depression received it.[42] The primary barrier to adoption are start-up costs and technical assistance provided in North Texas by Cloudbreak.

**Recommendations**

**Scale the Collaborative Care Model.** Congress can create similar momentum nationwide by providing grants to primary care practices and health systems, as well as technical assistance to enable them to implement CoCM effectively. While the 2016 CURES Act provided grants to community health centers, health systems and primary care practices more broadly need support to accelerate CoCM implementation, similar to action taken early in the last decade to speed adoption of electronic health records. Nationwide, primary care practices operate on thin financial margins with limited support staff, making implementing a new delivery model difficult. Establishing an integrated care program also requires up front expenses, such as hiring staff and purchasing or upgrading software and electronic health records. This can be a barrier to all practices, but especially those smaller, rural, and independent practices. In addition, in order to ensure that practices are successful with integration, technical assistance is also needed to help ensure fidelity to required staffing models, workflows, new technology, and

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[39] Wells, K., Sherbourne, C., Schoenbaum, M., Ettner, S., Duan, N., Miranda, J., Unützer, J., & Rubenstein, L. (2004, April). Five-year impact of quality improvement for depression: Results of a group-level randomized controlled trial. *Archives of General Psychiatry, 61*(4), 378–386. https://pubmed.ncbi.nlm.nih.gov/15066896/

Areán, P. A., Ayalon, L., Hunkeler, E., Lin, E. H. B., Tang, L., Harpole, L., Williams, J. W., Unützer, J., & IMPACT Investigators. (2005, April). Improving depression care for older, minority patients in primary care. *Medical Care, 43*(4), 381–390. https://pubmed.ncbi.nlm.nih.gov/15778641/

Ell, K., Aranda, M. P., Xie, B., Lee, P-J., & Chou, C-P. (2010, June). Collaborative depression treatment in older and younger adults with physical illness: Pooled comparative analysis of three randomized clinical trials. *American Journal of Geriatric Psychiatry, 18*(6), 520–530. https://pubmed.ncbi.nlm.nih.gov/20220588/

[40] Alter, C., Carlo, A., Henry Harbin, & Schoenbaum, M. (2019). Wider Implementation of Collaborative Care Is Inevitable. *Psychiatrics News*. https://doi.org/10.1176/appi.pn.2019.6b7

[41] For more information, please see: https://www.nationalalliancehealth.org/www/initiatives/initiatives-national/workplace-mental-health/pathforward

[42] Unützer, J., Harbin, H., Schoenbaum, M., & Druss, B. (2013, May). *The collaborative care model: An approach for integrating physical and mental health care in Medicaid health homes*. Health Home Information Resource Center. http://www.chcs.org/media/HH_IRC_Collaborative_Care_Model__052113_2.pdf

record keeping. In early 2021, scaling strategies similar to the above for CoCM were endorsed in comprehensive studies by both RAND[43] and the Bipartisan Policy Center.[44] These strategies are also fully aligned with the evidence-based services recommendations (Priority 2) of the Mental Health and Suicide Prevention National Response to COVID-19.[45]

Congressional action should also be taken to eliminate co-pays for CoCM in Medicare, Medicaid, and commercial coverage. Reducing barriers to collaborative care is critical to ensure patient engagement. Clinicians report patients choosing not to enroll or continue in the program because of the co-insurance requirements, despite understanding the benefits of the program and the potential for long term cost savings that occur when addressing mental health or substance use with CoCM. The negative impact of co-pays is particularly problematic for patients with high-deductible plans, and disincentives to address mental health and substance use disorders like these are a primary driver of comorbid physical conditions cited earlier.

Making telehealth waivers permanent, as discussed above, and full enforcement of the Mental Health Parity and Addiction Equity Act are equally important levers to increasing access to and reimbursement of needed mental health and addiction services.

It is also necessary for federal agencies to coordinate efforts across agencies, aligning policies and braiding funding. In addition to providing scaling grants, the Centers for Medicare and Medicaid Services (CMS) should align payment policies through Medicare and Medicaid, and the Substance Abuse and Mental Health Services Administration should align block grant and targeted grant funding to promote system development. The National Institutes for Mental Health can continue to push the envelope on service improvement with the more real-world focus that current leadership has provided, and the Department of Labor can align parity enforcement efforts in support. For the school-based efforts noted above, the Department of Education must also be on board, and for the 911 reforms noted below, so must the Department of Justice.

**Scale Early Intervention for Psychosis with Coordinated Specialty Care.** Coordinated Specialty Care (CSC) is the benchmark treatment for adults suffering from schizophrenia and other

[43] McBain, R. K., Eberhart, N. K., Breslau, J., Frank, L., Burnam, M. A., Kareddy, V., & Simmons, M. M. (2021). *How to Transform the U.S. Mental Health System: Evidence-Based Recommendations*. RAND Corporation. https://www.rand.org/pubs/research_reports/RRA889-1.html

[44] BPC Behavioral Health Integration Task Force. (2021). *Tackling America's Mental Health and Addiction Crisis Through Primary Care Integration: Task Force Recommendations*. Bipartisan Policy Center. https://bipartisanpolicy.org/wp-content/uploads/2021/03/BPC_Behavioral-Health-Integration-report_R01.pdf

[45] Read more about that here: https://nationalmentalhealthresponse.org/priority-2-calls-action

psychotic disorders.[46] Texas has been able to use federal Mental Health Block Grant (MHBG) funding thanks to the required CSC set-aside to implement 29 teams to date,[47] but we estimate that eight times as many teams are needed to meet the need statewide.[48] America's response to the pandemic has shown us that we can fully scale treatment if we have the will and resources to do so, and Congress could readily provide care to the 100,000 Americans in need each year by:

- Dramatically expanding the CSC set aside in the MHBG to fund program start-ups, and
- Requiring Medicare, Medicaid, and commercial payers to cover CSC care.[49]

**Address Social Determinants of Health for People with Severe Mental Illness and Addiction.** The American Rescue Plan includes substantial funding for housing, but decisions on how to invest these funds are left to local communities. We estimate that one in five homeless Texans in our major cities experience chronic homelessness, most due to complex mental health, substance use, and other debilitating health conditions. As additional infrastructure bills are considered by Congress, prioritizing use of federal housing funds for people with severe mental illness and addiction and fully funding permanent supported housing supports for the roughly 15% of people homeless in Texas who need dedicated, ongoing supports is needed.

People with severe mental illness and addiction also need to be prioritized for COVID-19 vaccines, given their higher rates of both infection and death previously cited. Last week, my Unified Vision colleagues Lisa Dailey, of the Treatment Advocacy Center, and Paul Gionfriddo, of Mental Health America, published an op-ed in The Hill[50] showing the way forward by:

- Allocating vaccines to inpatient psychiatric hospitals, community mental health centers, community behavioral health organizations and other mental health and substance use service providers best positioned to reach these groups,
- Creating multimedia materials for states and local communities to provide education about the importance of vaccination and dispelling myths about vaccine safety tailored to people suffering severe mental illness and addiction,

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[46] Kane, J. M. et al. (2016). Comprehensive Versus Usual Community Care for First-Episode Psychosis: 2-Year Outcomes from the NIMH RAISE Early Treatment Program. *The American Journal of Psychiatry, 173*(4), 362–372. https://doi.org/10.1176/appi.ajp.2015.15050632

[47] Intellectual and Developmental Disability and Behavioral Health Services Department. (2020). *Intellectual and Developmental Disability and Behavioral Health Services: Fiscal Year 2020 In Review*. Texas Health and Human Services Commission. https://mmhpi.org/wp-content/uploads/2021/04/IDD-BHS-Annual-Report-FY2020-003.pdf

[48] Meadows Mental Health Policy Institute. (2020). *Coordinated Specialty Care for Texans*. https://mmhpi.org/wp-content/uploads/2020/09/CoordinatedSpecialtyCare.pdf

[49] Jackson, B., Sternbach, K., Dixon, L., Harbin, H., Schoenbaum, M., & Rowan, M. (2020). *Payment Strategies for Coordinated Specialty Care (CSC)*. Meadows Mental Health Policy Institute. https://mmhpi.org/wp-content/uploads/2020/10/CoordinatedSpecialtyCare-PaymentStrategies.pdf

[50] Daily L. & Gionfriddo, P. (2021, April 21). We need a national vaccination strategy for people with severe mental illness. *The Hill*. https://thehill.com/opinion/healthcare/549484-its-time-for-a-national-vaccination-strategy-for-people-with-severe-mental

- Including peer support specialists deployed to community health centers and public health agencies to address emotional or mental health stressors related to vaccination for individuals with severe mental illness, and
- Gathering and publishing data on the vaccination rates on these groups to determine whether subgroups of people who experience multiple disparities can access vaccines.

**Reform Emergency and Crisis Response**

We have also witnessed during the pandemic the tragic consequences that result from our overreliance on public-safety response to mental health emergencies that require police agencies to carry the burden for the entire community[51] and the lack of inpatient treatment resources in virtually every community in the country,[52] systemic gaps that fall disproportionately on Black, indigenous, and other people of color.[53]

While national efforts to address crisis care through the 988 system and non-police response are making gains, there is still a need to reform the 911 emergency response system more broadly. Major communities across Texas are now doing just that, and earlier this year Austin was one of the first communities nationally to add a mental health response option to its 911 call center. This transformation focuses on the implementation of a health-driven response to mental health emergency calls through the 911 system and is based on a variation of the Multi-Disciplinary Response Team (MDRT) approach. The longest-standing MDRT program being implemented in Texas is the Dallas Rapid Integrated Group Healthcare Team (RIGHT Care),[54] and MDRT variations similar to RIGHT Care are being implemented with Meadows Institute support in large (Austin, El Paso, San Antonio) and smaller (Abilene, Galveston) Texas communities.

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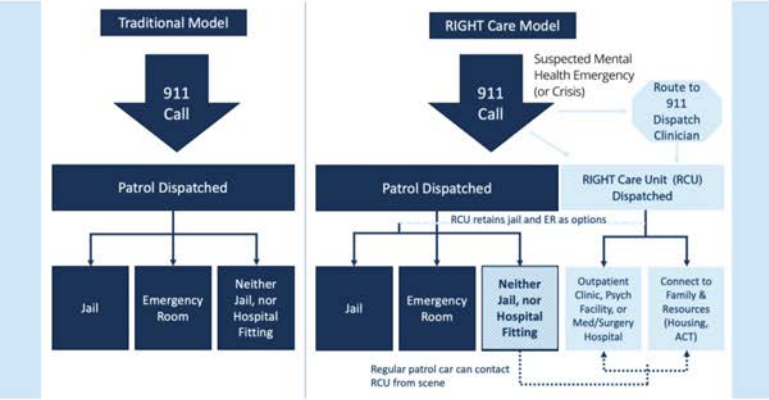
[51] Treatment Advocacy Center. (2019). *Road Runners: The Role and Impact of Law Enforcement in Transporting Individuals with Severe Mental Illness, A National Survey*. https://www.treatmentadvocacycenter.org/storage/documents/Road-Runners.pdf

[52] Eide, S., & Gorman, C. D. (2021). *Medicaid's IMD Exclusion: The Case for Repeal*. Manhattan Institute. https://media4.manhattan-institute.org/sites/default/files/medicaids-imd-exclusion-case-repeal-SE.pdf

[53] The Front End Project. (2021). *From Harm to Health: Centering Racial Equity and Lived Experience in Mental Health Crisis Response*. Fountain House. https://fountainhouse.org/assets/From-Harm-to-Health-2021.pdf

[54] For more information, see: https://mmhpi.org/project/right-care/

**Traditional Versus Reformed 911 Response With the Dallas RIGHT Care Model**




Texas is also implementing best practices to plan and coordinate 911 response, crisis response, and the broader mental health and substance use disorder treatment systems. A particular best practice is San Antonio's Southwest Texas Crisis Collaborative (STCC). STCC works operationally within the Southwest Texas Regional Advisory Council (STRAC), which coordinates emergency medical response for all health needs (including COVID-19) in the 22-county region surrounding San Antonio. STCC is now facilitating plans with the City of San Antonio, Bexar County, and mental health and substance use stakeholders to maximize the impact of COVID-19 relief funds and the American Rescue Plan to address mental health and substance use service needs, including housing, trauma response, and other social determinants.[55]

Congress can and should incorporate broader 911 reform, in addition to continued support for the development of 988 crisis response and community treatment capacity. STCC also offers a local model for the cross-agency planning and coordination recommended above.

### Improve Health Equity

Pre-dating the pandemic, Black, Indigenous, and other people of color across America faced systemic challenges accessing mental health care, with nearly three-quarters (73%) of Asians and Pacific Islanders, 69% of Blacks, and 67% of Latinos with mental illness not receiving

[55] For more information on STCC and STRAC, see: https://www.strac.org/stcc

needed mental health treatment.[56] Also prior to the pandemic, Black and Latino people were less likely to receive needed behavioral health services compared to the general population, and they are more likely to receive low-quality care.[57] Earlier in my testimony, we documented how COVID-19 has worsened these pre-pandemic inequities. All of the Texas-based reforms highlighted in my testimony – CPAN and TCHATT for children, Cloudbreak and CoCM for primary care based treatment more broadly, and MDRT-based 911 reforms – are all focused on addressing health inequities disproportionately impacting Black, Latino, and other Texans of color. Congress should continue to require specific metrics related to eliminating these inequities in all actions going forward, similar to requirements in the American Rescue Plan.

**Improve the Primary and Specialty Care Workforce**

Major deficiencies in the mental health and substance use disorder workforces are well documented, and two strategies being implemented in Texas are offered for further consideration. The first is simply the broad focus on primary care integration noted throughout my testimony. Primary care is the front line for the heart disease and cancer treatment workforce, and the strategies I noted earlier to expand the reach of primary care for mental illness and addiction are force multipliers for the behavioral health workforce.

We also need to expand the specialty workforce through peer specialists and community health workers with a broad emphasis on lived experience. As part of our Cloudbreak Initiative in North Texas, we are partnering with the Department of Global Health and Social Medicine at Harvard Medical School to deploy their EMPOWER program in North Texas in 2021 and with a Latino cultural adaptation in 2022. EMPOWER builds on path-breaking research demonstrating how non-specialist care providers can be trained and supervised to deliver brief psychological treatments for depression with just as much effectiveness as specialist-delivered treatment protocols.[58] This program greatly increases accessibility to mental health care because the care is delivered by community health workers (CHWs) who live and work with (and often share similar lived experience with their neighbors living in) marginalized communities that are currently underserved. Building on a decade of implementation research in India, we are on track to deploy EMPOWER to better expand the North Texas workforce to better reach

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[56] Chaves, K., Gray, D., Barton, B., Bonnett, D., Azam, I., Hahn, C., Goldstein, E., Hall, I., Harris, N., Muhuri, P., King, J., Lankford, A., Lau, D., Liang, L., Liu, S., Matosky, M., Matthews, T., Morgan, R., Moser, R., ... Valentine, M. (2020). *2019 National Healthcare Quality and Disparities Report*. Agency for Healthcare Research and Quality. https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrdr/2019qdr.pdf

[57] Snyder, C. R., Frogner, B. K., & Skillman, S. M. (2018). Facilitating Racial and Ethnic Diversity in the Health Workforce. *Journal of Allied Health*, *47*(1), 58–65. https://pubmed.ncbi.nlm.nih.gov/29504021/

[58] Patel, V., Weobong, B., Weiss, H. A., Anand, A., Bhat, B., Katti, B., Dimidjian, S., Araya, R., Hollon, S. D., King, M., Vijayakumar, L., Park, A.-L., McDaid, D., Wilson, T., Velleman, R., Kirkwood, B. R., & Fairburn, C. G. (2017). The Healthy Activity Program (HAP), a lay counsellor-delivered brief psychological treatment for severe depression, in primary care in India: A randomised controlled trial. *The Lancet*, *389*(10065), 176–185. https://doi.org/10.1016/S0140-6736(16)31589-6

communities of color and people living in poverty more broadly in late 2021. EMPOWER addresses the formidable barriers of training, supervision, and quality assurance with a suite of digital tools to train, supervise, and equip the CHWs to consistently deliver evidence-informed care.

**We Must Apply the Lessons of the Pandemic to Address the Epidemic**

In less than a year, America showed the world that we can learn now to detect, treat, and prevent a disease that we had never before seen. Over the last year in Texas, we have shown that rapid progress is both possible and broadly scalable for the longer standing scourges of suicide, overdose, and mental illness and addiction more broadly.

I am deeply grateful to the Committee for the opportunity to share information about these strategies, and I look forward to supporting the work of the Senate and the Administration to turn the tide on mental illness and addiction, just as we have for COVID-19 in the last year, and heart disease and cancer over the prior two decades, through early detection, evidence-driven and equitable care, and the will to implement known treatment approaches while we also continue to research even better care.

[SUMMARY STATEMENT OF ANDY KELLER]

**For over a decade prior to the COVID–19 pandemic, every leading indicator related to the pre-existing mental health and addiction epidemic was worsening**. Deaths from suicide, overdose, and co-morbid health conditions were at 20-year highs, compounded by systemic inequities for Black, indigenous, and other people of color. And **the COVID–19 pandemic has made all of this worse** over the last year:

- Rates of death from overdose are expected to exceed 88,000, the highest number ever.
- Indicators of depression have increased four-fold and suicide has doubled.
- Mental illness is the second leading driver of COVID–19 based mortality (after age).
- And the effects of COVID–19 worsened underlying inequities in multiple ways.

**The primary lesson that needs to be learned from the COVID–19 pandemic is that the Nation can rapidly scale up and deliver early detection, treatment, and prevention if we pair the will to act with the necessary resources**. Fortunately, this would be much easier to do for mental illness and addiction, because we already know how to successfully detect and treat most of these conditions. Universal access to just two evidence-based treatments—the Collaborative Care Model (CoCM) for depression and Medication-Assisted Treatment (MAT) for addiction—could save almost 40,000 lives a year from suicide (14,500) and overdose (24,000).

**We are scaling such solutions today in Texas, and this can inform national efforts**:

- In 2020, our 12 publicly funded medical schools launched the Texas Child Mental Health Care Consortium with $100 million a biennium to provide **universal access to child psychiatry consultation in primary care and urgent access to psychiatric telehealth care in schools**, engaging nearly 5,000 pediatric primary care providers and on track to reach 2 million Texas students with coverage in less than a year. We are also working closely with the Texas Education Agency (TEA) to create guidance and supports for local school districts. Congress should build on similar supports in the American Rescue Plan and scale funding commensurate with the national need and make regulatory relief on telehealth permanent.
- We are also **scaling measurement-based care (MBC) and the Collaborative Care Model (CoCM) in health systems** across Texas through our Cloudbreak Initiative. Congress can create similar momentum nationwide by providing grants to primary care practices and health systems, as well as technical assistance to enable them to scale effectively. It should also eliminate co-pays in Medicare, Medicaid, and commercial coverage. Full enforcement of the Mental Health Parity and Addiction Equity Act is also key, as is coordination across Federal agencies to align policies and braid funding.
- Texas has used Federal Mental Health Block Grant set asides to scale up the benchmark treatment for psychosis, Coordinated Specialty Care (CSC), but **Congress should partner with states to scale up CSC resources to reach all 100,000 Americans in need each year and require third-party coverage. Housing supports and vaccine outreach should also be targeted to people with severe needs**.
- Major communities across Texas are also reforming 911 response systems away from overreliance on public-safety to a health-driven response with Multi-Disciplinary Response Teams. **Congress should add broader 911 reform** alongside 988 crisis response and community treatment expansion.
- **Health equity broadly** and the **primary care and peer support workforces** must also be addressed.

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The CHAIR. Thank you so much, Dr. Keller.
We will turn to Dr. Muther.

**STATEMENT OF JONATHAN MUTHER, PH.D., VICE PRESIDENT OF MEDICAL SERVICES—BEHAVIORAL HEALTH, SALUD FAMILY HEATH CENTERS, AND CLINICAL INTEGRATION ADVISOR, EUGENE S. FARLEY, JR. HEALTH POLICY CENTER, COMMERCE CITY, CO**

Dr. MUTHER. Good morning. Thank you very much, Chair Murray, Ranking Member Burr. And Senator Hickenlooper, thank you for the introduction. Members of the Committee, thank you for the opportunity to testify on the critical topic of mental health and substance use disorders.

My name is Jonathan Muther, and I am the Vice President of Behavioral Health at Salud Family Health Centers, a federally qualified health system with 13 community health clinics in eight mostly rural counties throughout Colorado. We are one of 1,400 community health center organizations serving over 30 million Americans.

Health centers are the family doctor of people of all ages and walks of life—newborns, seniors, the homeless, veterans, and agricultural workers, just to name a few. Health centers provide easy access to services that would otherwise be unaffordable and unattainable. Care in our clinics involves a team of various professions, working together to address the physical, oral, behavioral, and social needs all in one place. This is the most efficient and accessible way to have the majority of mental illness and substance use disorders treated.

As a psychologist, I have seen firsthand the impact of COVID–19 on our communities. This includes the quadrupling of mental illness and substance use disorders within what was already an overburdened behavioral health system.

More than one out of three individuals are experiencing increased substance use, worsening anxiety, depressed mood, and, as has been mentioned, we are seeing unprecedented rates of suicide. Worse, even before the pandemic, over half of the individuals with a mental illness or substance use disorders did not receive care. This devastating gap in access to care has only worsened in the past year.

But, there are opportunities for things to get better, and I would like to put forth three key elements to improving healthcare that will address the problem.

No. 1, reinforcing primary care as the backbone of healthcare in this Country so we can properly address the mental, emotional, and behavioral demands that are most likely to present in these settings. It is essential to achieving better total health outcomes, containing costs, and relieving inequities.

No. 2, we must continue to innovate models of care, invest in behavioral health specialists working in concert with medical providers, and eliminate fragmented systems that do not allow for the whole-person approach.

No. 3, opportunities exist to transform behavioral health service delivery in a meaningful way that includes telehealth, advancing payment models, and enhancing our workforce.

We must engage in these strategies now.

To emphasize the work that must be done, I want to share a patient story of a man named Marco, a 38-year old gentleman, living

in a 600 square foot shipping container repurposed as housing, who was forced out of the food service industry due to the pandemic.

During a screening phone call conducted by a behavioral health provider, Marco stated, I am so surprised and glad to hear from someone. He endorsed multiple symptoms of depression and anxiety, alcohol abuse, and thoughts of suicide. Marco acknowledged, this is the first I have spoken to someone in days, and I never would have known what to do had you not called.

Waiting for individuals like Marco to ask for help is too late. We have to equip our clinics with behavioral health clinicians who can proactively outreach individuals like Marco, who would otherwise fall through the cracks.

To do this, it is essential to keep telehealth, as has been mentioned. Keep telehealth as a core aspect of service delivery. Telehealth has allowed us to provide mental health services at a rate on par with rates pre-pandemic. Very simply, telehealth reduces barriers to care.

We also need to build on existing advancements of alternative payment models. Many types of effective clinical encounters, including the one I mentioned with Marco, are not billable in a fee-for-service model. It is essential to reform our current payment models and governance structures so that outcomes and value are rewarded over volume.

A workforce pipeline is also needed that supports recruitment and retention into mental health training programs through loan forgiveness and other financial incentives. We should broaden the workforce to include roles like peer specialist, community health workers, and mental health first responders.

We must be strategic about workforce allocation and ensure that clinicians are able to treat professionals—excuse me—ensure clinicians are able to treat individuals and families where they are most likely to present, such as school-based health centers and primary care.

Quickly, I would like to fully endorse the work that has been done by the Bipartisan Policy Center. They have a report called Tackling America's Mental Health and Addiction Crisis Through Primary Care Integration. Their report further details what I have only been able to briefly touch on today.

But, the concerns are rising, the need is clear, and the solutions are there. We can and must do better.

Thank you again, Chair Murray and Ranking Member Burr. Thank you for allowing me to share my thoughts and ideas. Thank you for your attention to this important topic, and I look forward to questions.

Thanks.

[The prepared statement of Dr. Muther follows:]

PREPARED STATEMENT OF JONATHAN MUTHER

**Introduction**

Chair Murray, Ranking Member Burr, and Members of the Committee, thank you for the opportunity to testify on the critical topic of mental health and substance use disorders. My name is Jonathan Muther and I am the Vice President of Behavioral Health at Salud Family Health Centers, a federally qualified health system with 13 community health clinics in 8 mostly rural counties throughout Colorado.

As a psychologist, I have spent my entire career to date in a primary care community health setting. As a behavioral health clinician, I have seen first-hand the impact of COVID–19 on our communities, including and especially the worsening of both the frequency and severity of mental illness and substance use disorders. From this perspective, and the experiences of countless patients, I will be sharing my testimony today. There are three elements for improving healthcare I would like to put forth, these include:

1. Primary care is the backbone of health care in this country and properly addressing mental, emotional, and behavioral demands in this setting is essential to achieving better health, containing costs, and relieving inequities.
2. We must look at new models of care, including behavioral health specialists working in concert with primary care medical providers, in order to meet the demand for behavioral health care that has grown exponentially since the onset of COVID–19.
3. Opportunities exist to further transform behavioral health service delivery in a meaningful way that include telehealth, advancing payment models, and enhancing our workforce.

Salud is one of 1,400 Community Health Center organizations spread across 14,000 rural and urban communities serving over 30 million Americans. Health centers are the family doctor to people of all ages and walks of life—newborns, the seniors, the homeless, veterans, and agricultural workers. Health centers are problem-solvers, protectors of public health, and innovators in illness prevention, even in unprecedented pandemics like COVID–19. Health centers provide easy access to services that individuals would otherwise find unaffordable and unattainable. We look beyond the medical chart for answers that not only prevent illness but address the environmental and social factors that can make people sick—lack of nutrition, exercise, homelessness, and most certainly mental health, and addiction. In providing access to affordable care for people least likely to have it, unnecessary hospitalizations and ER visits are significantly reduced and so are costs to the American taxpayer.

Community Health Centers across the country have stepped up to meet the needs of the communities they serve first through continued care for underlying health conditions, as well as COVID–19 testing and vaccinations. Since the onset of the pandemic, health centers across the country have tested over 10 million patients and conducted over 3.6 million vaccinations. Nearly half of the patients vaccinated are racial or ethnic minorities.

**Health centers have been able to thrive in communities because of the ongoing support you have shown for federally Qualified Community Health Centers (FQHC)**. For example, the three-year extension of the mandatory Community Health Center Fund has provided multi-year certainty for my health center and others across the country. Additionally, the COVID funding from last year, along with the $7.6 billion from the American Rescue Plan is enabling health centers to care for their patients during this difficult time. Salud has received over $16 million from this funding and will now be better positioned to test, vaccinate and care for our patients. We are using this funding to hire staff for vaccine clinics, to develop, maintain, or resurrect programs related to quality improvement, and to develop meaningful changes the pandemic has brought on such as ensuring separate clinic space for sick and well patients. Most importantly, we seek to shrink the disparities that have always impacted communities of color that were made worse by the COVID pandemic.

A conversation about behavioral health (which includes mental illness and substance use disorders) is a conversation about *health*. There is no health without mental health. We know, from clinical experience and decades of research, that wellness promotion, improving mental health, and reducing risk for substance abuse, improves all health outcomes. **However, access to behavioral health treatment *is*, in and of itself, a health disparity**. Our current system allows for inadequate attention to be afforded to behavioral health treatment, coverage, and policy, as compared to medical care. This needs to change.

## Background

A model of integrated care involves a team of clinicians from various professions all working together to meet the healthcare needs of individuals and families. In a traditional model, you go to your doctor's office when you have a cold, and a separate dentist office for a toothache. And if one of these providers is able to identify a concern, or less likely, the patient is able to recognize they might be experiencing

symptoms of depression or anxiety, there might be a referral placed for a third visit in yet another clinic at another time. With each separate visit, patients face the added burden of transportation, time away from work or caring for children, another copay, and navigating a system that is confusing and disjointed because these treating providers cannot communicate with one another. In an integrated model, each of these concerns can be addressed in the same place on the same day. A visit to the doctor also includes a structurally embedded visit with a behavioral health provider—whether the patient is seeking this service or not. Just as height, weight, blood pressure and other routine information is gathered for the medical visit, so too are questions relating to mood, stress and substance use to inform the behavioral health part of the visit. This allows members of the care team to achieve a global picture of the presenting concern, and for the individual seeking care to know every aspect of their health is being addressed.

I oversee a team of about 40 behavioral health clinicians at Salud Family Health Centers that are dedicated to increasing access to behavioral health services for Coloradans every day. Each clinician conducts between 8–12 brief encounters per day, most often in the context of a medical visit, alongside a primary care provider, regardless of whether an individual has requested—or is even expecting—behavioral health as part of their care. Behavioral health providers coordinate, collaborate, and consult with medical providers to treat mental illness and substance use disorders, create health behavioral interventions for chronic physical health conditions, and most commonly, address comorbidities that often go untreated. We are seamless with patients receiving mental health treatment where they go to fill their medications, receive their COVID–19 vaccination, and get their annual physical.

However, we still face barriers—challenges that are driven by the fragmented system we operate in. The COVID–19 pandemic has exposed and exacerbated longstanding difficulties for individuals experiencing mental illness and/or substance use disorders. The challenges are many. However, I would like to focus my testimony on the *opportunities* we have to do better for the individuals and families of this country.

We must look at innovative practices that focus on integrating behavioral health and primary care as a means to reducing the silos that have historically existed within our healthcare system. We have decades of reports and evidence that integrating mental health into places like primary care works. And while these models still are a novelty and not so much the standard of care, we should pursue a system that prioritizes a whole-person approach, in which addressing an individual's entire health needs, be it behavioral and emotional, oral, medical, or social, begin and end in one place—ideally the place of the person's choosing.

**The Value of Integrated Care Over Traditional "Siloed" Care**

A set of professionals from various disciplines working together in one place increases efficiency, has demonstrated cost-effectiveness, and improves health outcomes. The integration of behavioral health and primary care is the linchpin to resolving our inadequate system of care for both behavioral and physical health outcomes. We can no longer afford, neither fiscally nor in reduced quality of life; neither in untold healthcare spending nor well-intended grant dollars; neither in increasing rates of deaths by suicide nor other deaths of despair, to maintain the outdated, entrenched silos that separate physical and behavioral health.

Like all health-related concerns, we know that individuals with mental illness or substance use disorders are most likely to initially present for help at their doctor's office. A model of integrated primary care allows for brief behavioral health assessments and interventions offered in real-time, at the point of contact with one's primary care provider. This model is effective, efficient, and suitable to consumer needs and preferences.

I want to share the story of "Marco", a 38-year-old man and patient at Salud Family Health Centers, living in a 600 square foot shipping container repurposed as a rudimentary home in rural Colorado. He has no running water and a small wood-burning stove for heat. He had previously been employed in the food service industry until he was forced out of work last April. During a screening phone call by a Salud behavioral health provider—a routine outreach effort to assess need and "normalize" behavioral health as part of care, Marco stated, "**I'm so surprised and glad to hear from someone, this is exactly what I need right now.**" He then endorsed multiple symptoms of depression, anxiety, alcohol abuse, and thoughts of ending his life. The patient acknowledged, "**this is the first I've spoken to someone in days and I never would have known what to do had you not called**." Waiting for individuals like Marco to ask for help is too late. Expecting Marco to

know where to receive help from a system with uncertain points of entry is unrealistic. We have to equip our clinics with behavioral health clinicians who can proactively outreach individuals experiencing the many barriers to care.

This model needs to be incorporated in all clinical settings. Primary care and school settings are the most likely starting points for accessing behavioral health services for adults and children, respectively. Placing behavioral health providers where individuals are most likely to be allows clinicians to proactively address the rising rates of mental illness and substance abuse risk factors. Integrated models must be the norm in other settings as well, including specialty medical clinics, hospitals, and emergency departments. Imagine an avoidable emergency department visits because of a timely intervention when an individual disclosed stress to their primary care doctor.

**Prevalence of Behavioral Health**

Even prior to the COVID–19 pandemic, there was a mental health crisis in the country related to unmet need, in which the demand for services far exceeded our capacity to adequately address the rates of distress. **Over half of American youth and adults living with a mental illness or substance use disorder report receiving no treatment**. Pre-COVID, rates of adult mental illness of any type were about 19 percent on average (ranging from 16–25 percent).[1] Over 20 million Americans aged 12 or older in this country experience addiction and substance dependence.[2] Of these adult individuals who report a mental illness, as many as 57 percent report receiving no treatment. Of the nearly 14 percent of youth experiencing symptoms of depression, almost 60 percent did not receive any mental health treatment. Adults experiencing a substance use disorder fared even worse, with as many as 80 percent reporting they did not receive treatment.

**Furthermore, since the onset of the pandemic, rates of mental illness have multiplied, and the unmet need is now further burdening a system already cracking at the seams**. Even more alarming is the mental health impact on our Nation following the pandemic will last far beyond the physical health impact and into future generations.

No segment of our population is immune to the toll that necessary disease mitigation efforts have had on our collective psyche. Social isolation, financial uncertainty, job loss, and loss of a loved one are risk factors for mental illness and substance use disorders. The very measures needed to keep our communities safe, including physical distancing, stay-at-home orders, school closures, and others, have unintentionally increased the risk and put forth new challenges on our behavioral health system.

Unsurprisingly, prevalence rates for mental illness and substance use disorders are rising at a staggering rate. **US adults with symptoms of an anxiety disorder and/or depressive disorder has at least quadrupled since before the pandemic**.[3] The CDC has reported rates of anxiety to be three times higher and rates of depression four times higher in 2020 as compared to the year before the pandemic. That makes 30–40 percent of our population currently experiencing these symptoms as compared to 11 percent in 2019.

We cannot ignore the fact that these rising rates of mental illness and substance use are disproportionately affecting specific populations of our country. Younger adults (18–26 years old), racial/ethnic minorities, essential workers, and unpaid adult caregivers reported having experienced disproportionately worse mental health outcomes, increased substance use, and elevated suicidal ideation as a result of the pandemic.

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[1] Mental Health America, State Ranking (2020). *https://www.mhanational.org/mentalhealthfacts*.

[2] Substance Abuse and Mental Health Services Administration (SAMHSA) (2021). Key Substance Use and Mental Health Indicators in the United States: Results from the 2019 National Survey on Drug Use and Health. *https://www.samhsa.gov/data/sites/default/files/reports/rpt29393/2019NSDUHFFRPDFW HTML/2019NSDUHFFR090120.htm#:~:text=Among-percent20the-percent2020.4-percent20million-percent20people,alcohol-percent20use-percent20disorder percent20and-percent20an*.

[3] Centers for Disease Control and Prevention (CDC). Morbidity and Mortality Weekly Report, August 14, 2020. (Czeisler et al. (2020). Mental health, substance use, and suicidal ideation during the COVID–19 pandemic—United States, June 24–30 2020. *Morbidity and Mortality Weekly Report, 69 (32)*, 1049–1057. *https://www.cdc.gov/mmwr/volumes/69/wr/pdfs/mm6932a1-H.pdf*.

**Redesigning Behavioral Health Post COVID–19**

First, we need to ensure that telehealth continues to be a core platform of health care delivery. Prior to 2020, only 1 percent of mental health was via telehealth and skyrocketed to 75 percent of visits during 2020.[4] The increased presence of telehealth during the pandemic has been a saving grace. It has allowed us to maintain a rate of service delivery roughly on par with rates of delivery pre-pandemic, but in a way that decreases barriers to care. Like utilization rates for all healthcare, behavioral health utilization fell. However, the behavioral health utilization soon came back to rates equal to that or higher than rates seen in 2019 because of the deployment of telehealth. **Yet we must remember, the gap of unmet need has still widened further because of the dramatic increase in prevalence rates due to COVID stressors**.

Therefore, we need to continue to utilize smart technologies in innovative ways and think beyond the realm of a traditional therapy session. Examples include more frequent symptom screenings, periodic check-ins with clinicians (e.g., brief instant messaging) in addition to a typical in-clinic visit, and virtual group visits and group chats, all designed to maximize interventions and extend the availability of our limited number of licensed clinicians.

Second, we need to build on the existing advancements of alternative payment models. Marco's experience reminds us of the importance of a meaningful intervention that occurs because of proactive outreach to patients. We can no longer force a patient to experience the barriers of limited transportation, high cost of care with insurance that does not cover behavioral health treatment equitably, long wait lists, and stigma. This is especially true for those whose first language is something other than English.

But payment without addressing coverage is only telling part of the story. We know that many patients avoid care because of the cost, and despite mental health parity being a Federal law for decades, we still have limited enforcement. In fact, under current law, the United States Department of Labor lacks the ability to assess civil monetary penalties against health issuers and plan sponsors for violations of the Mental Health Parity and Addiction Equity Act (MHPAEA), which requires insurers to cover illnesses of the brain, such as depression or opioid use disorder, no more restrictively than illnesses of the body, such as diabetes or cancer. Without this power, USDOL can only require plans to reimburse consumers for wrongly denied coverage of care that was nevertheless provided. Such meager authority is not enough and is unlikely to change plans' coverage practices. USDOL must finally be able to hold plan issuers and sponsors accountable for illegal denials of mental health and substance use coverage more than 12 years after enactment of the MHPAEA.

**The types of clinical encounters that I have described may not be billable at all**. If these services are reimbursable, then it may be at an extremely low rate, and/or require only certain credentials to obtain reimbursement under current payment models and governance structures. These are exactly the types of clinical encounters that are meaningful for the patient, efficient for the clinician, and a perfect example of the type of flexibility in service delivery that service organizations are seeking to provide under alternative payment models that reward outcomes and value over volume. We need to pursue other encounter types such as brief screens and check-ins with patients, commensurate with their clinical needs and not bound by outdated payment and regulatory constraints. **This is attainable for the vast majority of those needing behavioral health services**. We must reform our billing and reimbursement models if we are to prevent an ongoing undercurrent to this current pandemic for generations to come.

Prior to the pandemic, clinics like mine were not able to bill for telehealth services in any capacity. Congressional action through the CARES Act and other state-based initiatives have enhanced flexibility in payment for telehealth services allowed us to switch our clinical approach, quite literally overnight, to an approach that is easy and effective for both clinicians and consumers of behavioral health. But we need more. **Telehealth services must be here to stay if we want progress in closing the gap between unmet need and service acquisition**. Telehealth services, regardless of mode/platform (phone, video conference, face-to-face in-person) should all be reimbursed and at the same rate. As a result, I would encourage you to con-

[4] Davenport S., Melek, S., and Gray, T.J. (2021) Behavioral healthcare utilization changes during the COVID–19 pandemic: An analysis of claims data through August 2020 for 12.5 million individuals. *https://wellbeingtrust.org/wp-content/uploads/2021/03/Milliman-COVID-BH-Impact-2021-02-17.pdf*.

tinue the telehealth flexibilities that the Public Health Emergency has enabled, including recognizing health centers as distant site providers and removing originating site restrictions, as well as allowing the use of audio-only encounters.

**We must also increase the workforce and invest in a robust pipeline that supports recruitment and retention of individuals of diverse backgrounds into mental health training programs** through loan forgiveness programs and other financial incentives to make this career attractive and sustainable.

At Salud, we have a training program bringing in highly skilled clinicians from Puerto Rico to help meet the needs of a culturally and linguistically diverse community. Once the pipeline has been created and our healthcare system is attracting and supporting behavioral health-trained clinicians, we must also broaden the workforce to be more inclusive of other roles like peer specialists (individuals with lived experience of mental illness and/or substance use disorders), community health workers, mental health first responders, and others.

Health centers have tripled their behavioral health staffs over the last 10 years, performing evidence-based screenings and intervention, including Medication Assisted Treatment and referral. However, demand remains very high with nearly a five-fold increase in patients seeking treatment for opioid addiction and other substance use disorders. **The recent investment of $1 billion for the National Health Service Corps and the Nurse Corps is an example of the large-scale commitment to the health care workforce that is needed to address severe and chronic workforce challenges at the community level**. Let's continue this line of investment and seek to train this new workforce in mental health as well.

What cannot be overstated, is **the allocation and distribution of our workforce needs to be where presenting concerns are most evident**, namely primary care and schools. Another example, the mental health first responder, often termed the "co-responder" model, is among the most innovative and should be expanded. This enables the provider to appropriately address the needs of the patient at the first point of contact, averting expensive emergency department visits. It also avoids the "criminalization" of mental illness and prevents unnecessary involvement with law enforcement and corrections, which unfortunately has become the "defacto" mental health system.

Last, I would like to fully endorse the work done by the Bipartisan Policy Center (BPC) and the recommendations included in BPC's recent report entitled, *Tackling America's Mental Health and Addiction Crisis Through Primary Care Integration*. I believe the report offers a clear distillation of the current challenges and provides additional recommendations to chart a new path forward.

**Conclusion**

The concerns are rising. The need is clear. We know what will happen if we expect our current system to accommodate the quadrupling of need. More than 1 out of 3 of our fellow citizens right now are experiencing the effects of increased substance use, feelings of worsening anxiety, and/or significant impacts on their mood as a result of depression.

The good news is that health centers are a proven model of care and are staffed with dedicated professionals who know how to help. We know where to be so that we can ask the right questions and offer the right help and make the right recommendations. We have shown that we can improve the health of our communities by making it normal to treat the emotional toll of stress and illness when you go to school or see your primary care doctor. We have the road map, but now need to ensure we have the resources, so the roads are sturdy and equipped to handle the increase in traffic needed to get to our destination of improved health and well-being for us all.

Again, Chair Murray and Ranking Member Burr thank you for allowing me to share my thoughts and experiences from Salud Family Health Centers. I appreciate your commitment to these issues and would welcome any questions that you may have.

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The CHAIR. Thank you so much, Dr. Muther, and thank you to all of our witnesses today.

We will now begin a round of five-minute questions of our witnesses. I, again, ask my colleagues to please keep track of your clock, stay within the 5 minutes.

In the midst of the COVID–19 pandemic, the Country has also been grappling with systemic racisms and resulting health inequities, both of which had significant impacts on mental health. COVID–19 has been hardest on communities of color, who also continue to have less access to mental healthcare and substance use treatment options.

I would like to hear from each of you. In your view, how can we ensure mental health and substance use disorder treatments are accessible and affordable to communities of color and others experiencing greater need?

Dr. Muther, I will start with you.

Dr. MUTHER. Well, thank you very much for the question and the opportunity to speak to that.

You know, in addition to the challenges faced by individuals of color, you also mentioned in your opening comments, Chair Murray, some of the other barriers to care that include affordability or lack of capacity to find a provider. And this is the importance of the emphasis on the integrated primary care model, is we address all those barriers to care, and we strategically place clinics, and through telehealth, certainly can do more intentional outreach to those individuals most likely to be experiencing difficulties to access to care.

But, I think there is an intentionality in access, increasing access, and making it easy. So, when individuals come to their primary care doctor, we also are able to provide a behavioral health clinician in the same time, at the same place in order to proactively recognize early on symptoms of mental illness and substance use disorders and providing meaningful interactions.

Both with the telehealth and providing the team-based approach is the best way to ensure that we are meeting the needs of those most vulnerable.

The CHAIR. Dr. Benton, do you have any thoughts on that?

Dr. BENTON. Thank you, Chair Murray. This is an excellent question. I agree with Dr. Muther's comments. The underserved populations, for minoritized populations, particularly during—before and during the pandemic, there were significant concerns around access and engagement in care. And what we have done is created approaches that require us to do more outreach.

In addition to that, we have had to look at culturally competent interventions to engage minoritized populations in care. So much of the data is very clear that frequently, minority youth are seen in emergency care or crisis programs, but less than 50 percent of them actually receive the follow-up care that is needed for treatment.

We have to look at ways to use patient navigators, peer navigators, as Dr. Muther mentioned, to do consistent outreach and to make sure that those connections are made.

Increasing diversity among the caring—caregiving workforce would make a tremendous difference. So, as you are aware, the number of physicians and psychologists who are minority populations is actually quite limited. And, so, you know, we will never catch up so that there is actual matching based on race. But, what we can do is build cultural competence among the clinicians who

are working with minority populations to engage and retain them in care.

The CHAIR. Thank you.

Dr. Goldsby.

Ms. GOLDSBY. Thank you. In addition to the other two responses, which I agree with, in South Carolina, we have mental health and addiction services in every single county in the state where anyone, regardless of their ability to pay, can access services. But, we agree that more outreach and engagement needs to be done, particularly in underserved communities and in rural pockets of some of our counties.

Over the pandemic, we did a couple of things to address this. First, with our SC-HOPE support line, we made sure that Spanish-speaking support was available through that support line, and we advertised that state-wide and were surprised to get a number of calls of our Spanish-speaking population to that support line to engage in services with translational services.

In addition to that, we have been and continue to be doing more outreach events with trusted local leaders with our behavioral health providers, using mobile services to get into faith communities, residential communities, and rural areas where folks are in need of services but would not typically leave that area or transport to a center for services.

I think that this is really just a theme and a trend of going to where the folks need the services instead of waiting for us, but waiting for them to come to us.

The CHAIR. Okay.

Dr. Keller, I am running out of time, but I want you to have an opportunity to answer the question, so go ahead.

Dr. KELLER. Well, I appreciate it. Fortunately, I agree with everything my colleagues said. I think the primary care, in particular, is critical.

I would just emphasize three quick things. Community health workers can expand the diversity of our workforce, but we should technology-enable them. There is things we can do to help them be more effective, and I shared some of that in my written testimony.

Second thing is to remember, with telehealth, that audio-only gets access now. We need more broadband, but almost everyone has a phone. Medicare adding audio-only was a huge improvement. Please keep that.

Then the third thing is 911 reform. It is great that we are doing 988 and setting up crisis services, but people are still going to just call 911, and we need to make sure that people with health needs get health responses, not public safety responses.

The CHAIR. Thank you very much.

Senator Burr.

Senator BURR. Thank you, Chair.

Here is my takeaway from hearing all the testimony. Telehealth has been a key to treatment during COVID and it must not be rolled back post-COVID.

Here is my question to each of you. And this is really a yes or no answer, and I will go to you first, Dr. Keller.

Do you believe that Medicaid should require assignment of a medical home to every beneficiary for both the coordination of clinical and behavioral care?

Dr. KELLER. Yes, as long as that is a primary care practice.

Senator BURR. Dr. Muther.

Dr. MUTHER. Yes. There are challenges with comprehensive and complete attribution, such as people moving around and difficulties with care coordination. But, the answer is absolutely yes.

Senator BURR. Ms. Goldsby.

Ms. GOLDSBY. Well, NASADAD may not have consensus on that. I will say, in South Carolina, we would probably see some benefit for that guaranteed connection to services, especially with some payment reform, to ensure payment for success.

Senator BURR. Dr. Benton.

Dr. BENTON. Yes. You have got a consensus. I agree. This should be an option, primary care.

Senator BURR. Ms. Goldsby, your program, I think, is forward-looking and, during the pandemic, it has leveraged data to best target overdose hotspots and respond to the emerging trends that you saw. What are some of the successful changes that you think ought to stay in place after we have moved past the pandemic? And, what would you have done differently?

Ms. GOLDSBY. I think some of the success that we have seen in this state is the coordination, communication, and collaboration that we have done during the pandemic to make sure that we are responding to citizens' needs in real time across sectors.

You noted our rapid response team to address overdose, and we are going to continue that because as we, with public safety, public health, look at the overdose occurrences in our state with weekly surveillance and a communication framework that drives local action. We communicate with locals as we see hotspots for overdose in real time and drive their innovation for addressing overdoses with unique ways. You know, outreach and engagement again being the key, going to where the folks need the services, offering support and intervention in those locations.

Lessons learned, I think we knew that isolation was going to drive addiction as soon as we saw isolation measures being taken. That old adage that the opposite of addiction is connection, that is really true. I think that, you know, lessons learned, we needed to be even more proactive on engaging, on engaging, engaging. Keeping people connected to peer support specialists and to counseling. We did the best we could, but you know, I think the connection is key.

Senator BURR. Dr. Muther, how does a community health center work in partnership with other organizations in the community to improve access to behavioral care? And has that changed during COVID?

Dr. MUTHER. Such an important question, and thank you for asking it.

Connection with community partners is absolutely critical. So, the statements that I made and the moment—excuse me, the model that I put forth as it relates to integrated primary care is best to treat individuals up to mild to moderate—subclinical stressors up to mild to moderate severity. We need to rely on and

partner with and really integrate and partner intimately with our specialty mental health practices so that they are able to treat individuals of higher severity that present to our clinics on a regular basis, but yet we are not ideally suited to meet their needs from an acuity and higher severity standpoint.

That is—so we need to partner and build bridges as it relates to provide the full spectrum or the full continuum of behavioral healthcare.

Not only that, we need to partner with other community agencies to better address social determinants of health, such as housing, food, transportation, education, employment, some of those other basic needs that greatly impact healthcare.

Senator BURR. Madam Chair, let me just add, as we started into this phase of vaccination, I always thought the greatest motivation to be vaccinated was you are not going to go to the hospital and you are not going to die. Having been vaccinated, I now know that the greatest reason to be vaccinated is the first hug that you are able to give somebody that you have not been able to do for a year. And I think sometimes we look at the obvious things in the wrong order, and the ability to interact with each other, to do the things that we naturally have always done. For those to be able to happen again are the greatest motivating factor, and you can understand why there has been a mental health problem.

I thank the chair.

The CHAIR. Thank you, Senator Burr.

Senator Casey.

Senator CASEY. Chair Murray, thank you very much.

I want to thank our panel for providing the kind of perspective on these challenges that I am not sure any of us—or at least I was not able to fully appreciate until more recently.

I want to start with Dr. Benton. Doctor, as you emphasized in your testimony, it is absolutely critical that we address these workforce challenges that you and others have spoken about, not only by attracting new healthcare providers, but also by cross-training primary care clinicians and other providers.

We know that unless we equip more providers with the knowledge they need to respond to these really significant mental health concerns, far too many of the 15 million children and adolescents nationwide who are in need of care from mental health professionals will go without it, thereby facing terribly debilitating challenges throughout their development and well into adulthood.

In addition to loan forgiveness—and I know you spoke about loan forgiveness in your testimony—as well as other programs to incentivize healthcare providers to choose to work in the mental health field, it is also important that we consider how we could better integrate mental health competencies into medical education and graduate medical education.

Here is the question. How can we engage students of medicine and other health professionals, or professionals who are continuing their education, how can we engage all of them in mental healthcare?

Dr. BENTON. Thank you for that question. So, currently, there are multiple initiatives focused on engaging primary care providers and other partners in mental health treatments. Some of those ef-

forts involve consultation through access programs where, you know, pediatricians and other primary care providers, school counselors, can pick up the phone and call a mental health professional in their region. And many of these programs are regional. Many of them are national. It is one way that clinicians can get real time support for mental healthcare access and expansion of their knowledge.

There are also many national programs that are focused on educating primary care providers to have more mental health expertise given that over 30 percent of the chief complaints presenting to pediatricians are mental health concerns. So, primary care is absolutely the way to go.

One of the barriers to education for pediatricians and a barrier to actually providing the service really relates to reimbursement for their time. So, currently, the primary care providers have very limited time for physicals, for well-child visits, which are frequently the times that families present these complaints to their pediatricians, and they really do not have a way to respond.

Some things we could do to address that is increasing the number of mental health clinicians, such as social workers, case managers, community workers, that are integrated in these primary care settings. There is opportunities for increased consultation with mental health professionals, which is a way for people to learn about mental health treatments, working side by side in partnerships with medical professionals.

There are some easy wins and easy ways to increase the competencies of professionals who are working with children and adults who are impacted by mental health conditions.

Senator CASEY. Dr. Benton, thank you, and I want to thank you for the work you do at CHOP. It has never been more essential.

For my last question, I turn to Dr. Keller. You spoke of the Texas Child Mental Healthcare Consortium's work to expand child—I am sorry, to expand psychiatric telehealth care in schools and its partnership with the Texas Education Agency on systemic supports for mental health. This is a critical partnership. And I just wanted to ask you, in your experience, what kind of guidance and support do states and local school districts need to comprehensively respond to mental health needs?

Dr. KELLER. Well, thank you, Senator Casey. I think the first thing we need to do in conceptualizing that is we need to think of it reaching every student. I mean, we can't just think of incremental, like let's add one more counselor.

We need to have a comprehensive plan. And that is a lot of what we are partnering with the Texas Education Agency on, is to develop guidance to school districts, to the agencies that support school districts, so they can develop a multi-tiered system of supports, framework within the school, that looks not just at students in need, but students at risk, as well as healthy emotional development, as well as an interconnected schools framework that makes sure that the healthcare providers in that community are available to respond when there are needs.

Because schools are not health providers. They are education providers. And that is basically what our medical schools did. They put together a telehealth network to be that interconnected sys-

tems framework for schools that did not have other ways to provide care to their students.

Senator CASEY. Doctor, thanks very much.

Thank you, Chair Murray.

The CHAIR. Thank you.

Senator Collins.

Senator COLLINS. Thank you.

Ms. Goldsby, I would like to start with a startling statistic. More Mainers died of drug overdoses last year than died from COVID. We set a new record of 502 Mainers who died from drug overdoses. That was an increase of more than 30 percent from 2019.

Now, COVID clearly played an indirect role through the increased isolation, the cutbacks in peer-to-peer counseling, the lack of the ability to deliver services in rural Maine, where approximately 15 percent statewide of households do not have access to high-speed internet, so they cannot participate in telemedicine sessions. So, this is a real problem.

In Maine, we have seen access to high-quality mental health and addiction treatment through the expansion of certified community behavioral health clinics. I am wondering if you are familiar with these community-based hubs for behavioral healthcare and how you see them fitting into our national strategy to combat this terrible problem.

Ms. GOLDSBY. Senator Collins, thank you for the question. And I just want to say that South Carolina experienced remarkably similar impact from overdose last year. Our rates are also up. We had record-breaking rates of overdose in the month of May last year, and we expect to have lost more South Carolinians in 2020 than ever before from opioid overdose.

In our state, we have a county alcohol and drug authority and a community mental health center in every county in the state, that is open to any citizen for services, regardless of their ability to pay and regardless of their diagnosis.

The community mental health center model that you speak of, unfortunately, we do not have any of those centers in our state. We know that I think 19 or so other states do have those and that they have been successful programming. So, I cannot speak specifically from South Carolina's perspective, but we know that they are effective in other states.

Senator COLLINS. Thank you.

Dr. Keller, I want to follow-up with you on telehealth. I totally agree with Senator Burr's comments that we need to make this a permanent part of our healthcare structure.

Earlier this month, I visited the Aroostook Mental Health Center new adult stabilization unit, which recently moved into a new facility to increase its bed capacity. It provides crisis beds in very rural counties in Maine. It serves three counties.

Now, here is what is interesting to me. What the center reported to me is, through their outpatient services, where they do use telemedicine, that they had actually seen a 20 percent increase in mental health visits and a sharp decline in no-shows or cancellations as a direct result of visits that were virtual. Similar, the head of a major hospital in Maine told me that for mental health services,

their no-show rate had dropped to zero since they switched to telemedicine.

In addition to the need to expand telemedicine so those 83,000 Maine households have access, is there also a benefit—because there are still some people in this Country, particularly groups that have been known for not embracing mental health services in the past—namely men, individuals on Medicaid, and patients over age 65—having access through telemedicine where they may not feel the stigma, which unfortunately, regrettably, still is attached to seeking help for mental health problems?

Dr. KELLER. Senator Collins, that is a great question, and your point is right on. That, in fact, is the dynamic which leads telehealth to be so successful. One of the main ones is the lack of stigma. We have seen exactly the same things across Texas. Productivity targets being exceeded by 33 percent; no-shows dropping to zero.

The other thing is the research shows that telehealth works in many cases better, and I think that is because of that anonymity. It is a little easier to sort of tell the truth. I mean, you see that sometimes in email. People will write things in email they would never say in person. That can kind of happen sometimes in the therapeutic exchange, as well.

Please include audio-only when you make those things permanent because that is a huge expansion, particularly in rural areas, impoverished areas, that will get broadband one day, but it is still going to be expensive. And I think, you know, the phone is a great way to do that.

Could I just add that we have many certified community behavioral health centers in Texas, and they are doing exactly what you said they are in terms of being able to provide that comprehensive help, and we thank Congress for expanding funding there and encourage you to do more.

Senator COLLINS. Thank you so much.

The CHAIR. Thank you.

Senator Kaine.

Senator KAINE. Thank you, Chair Murray, Ranking Member Burr. And what a great witness panel. This is the hearing that makes me wish we had 30-minute question rounds because there is so much I would want to talk to you about. I think where I will start is a passion of mine, which is the mental health needs of our healthcare providers, keeping our healers healthy.

This week marks a year from the death by suicide of a very talented New York emergency room physician, Lorna Breen, who was a Virginian, family from Charlottesville, and I have worked together with her family and others to kind of promote keeping our healers healthy.

I recently re-introduced with a great bipartisan group of colleagues a bill, the Dr. Lorna Breen Healthcare Provider Protection Act, to really push this issue of mental health for frontline healthcare providers. With the strong advocacy of Chair Murray, we were able to get $140 million of funding for these efforts in the American Rescue Plan. That is great. I am hoping that we can now move to pass the underlying bill S. 610 to ensure that HHS imple-

ments the provisions and uses the funds consistent with congressional intent and, in doing so, honor Dr. Breen and others.

Chair Murray, I would like to submit for the record a letter of support for S. 610 from both Jennifer and Corey Feist, Dr. Breen's sister and brother-in-law, but also a second letter from a coalition of 31 other national medical and healthcare organizations.

The CHAIR. So ordered.

Senator KAINE. If I could just ask the witnesses, either—what should—I think we know some things Congress should do. But, what should states do and what should healthcare providers—hospitals or healthcare networks or community health centers—do to really promote healthy practices among our healthcare professionals and reduce any stigma or worry that people might have that, if they seek mental health counseling, could their licensure, could their credentialing, could their jobs, be at risk? That was a sad factor in Dr. Breen's life. Tragically, she did not feel like she could seek help without her professional career being somewhat at risk for doing that.

Share with us what states and healthcare providers can do to help with this challenge.

Dr. BENTON. Thank you, Senator, for that question. That is an incredibly important issue that you have highlighted.

States could work with their regulatory and licensing agencies to eliminate the repercussions of reporting on mental health conditions. So, now, many physicians are very afraid to report that they have ever had a mental health concern, particularly if there was a substance use concern, for fear that they might lose their license, and that is a major barrier to seeking care.

There is the remaining stigma of mental health, and many physicians work hours that are not easily available for treatment. Telehealth actually provides some opportunities for flexibility in care, and being able to support the continuation of telehealth would actually be supportive to physicians who are seeking care.

Then, I think there is a—must be the recognition that physicians often will not seek care for a variety of reasons.

But, the regulatory issues are major barriers to seeking sufficient healthcare for physicians. And advocacy at the state level to eliminate the barriers, the questions, or the repercussions for positives to the questions would be really important.

Senator KAINE. Dr. Benton, when you were speaking, Dr. Keller was nodding a lot, so I think maybe I will see if Dr. Keller——

Dr. KELLER. Yes. Well, I am so glad Dr. Benton said that. I mean, we single out addiction and depression and mental illness in ways we do not single out other debilitating illnesses. So, we stigmatize into our regulatory frameworks. We need to remove that stigmatizing language and create an even playing field around functional impairment.

The second thing we need to do is prepare for more. We did not see PTSD rates go up during the wars. It was when people came home. And, so, in the years ahead, and we know that post-traumatic stress is normal. Post-traumatic stress disorders are something we can prevent. So, we have to normalize the experience that people are going to suffer from post-traumatic stress. Its rates are going to go up after the pandemic recedes. Because right now, peo-

ple are kind of caught up in the sort of still kind of making through the disaster, through the trauma, of actually responding to the pandemic. And once that actually pressure goes down—we have seen this after hurricanes, after people come back from war. It is in the years after you return that you start to see the problem.

We have to prepare for this for the long haul and normalize that post-traumatic stress is something, of course, you are going to experience by going through this. But, if we can give sort of a moral framework for that and a support for that and to say that is something that you can still practice effectively, that will really help people not just seek care, but prevent illness.

Senator KAINE. In conclusion, Chair Murray, just one thing. I really am worried about this, not just for healthcare providers, but I am really worried about it for first responders—police, EMT, fire. It has been such a tough year. And, you know, the police issues tend to always be in the Judiciary Committee. But, I will tell you, when I go out and talk to law enforcement professionals there, and first responders, they usually are bringing up mental health before they bring up anything else. And, then, if we start with mental health, usually the whole meeting ends up being about mental health. So, there may be an opportunity for this Committee to look at some of the needs of our first responder community with kind of a different lens than maybe a judiciary committee might, and I hope we might consider doing that sometime in the future.

The CHAIR. Excellent suggestion. Thank you, Senator Kaine.

Senator Cassidy.

Senator CASSIDY. Way to go, Senator Kaine. Whenever you ask a chair to take on more jurisdiction, I find it is very receptive, so——

The CHAIR. Always. Always.

Senator CASSIDY [continuing]. Good job.

[Laughter.]

Senator CASSIDY. I am with you, Madam Chair.

Dr. Keller, I am also a doc, and I worked with Senator Chris Murphy back in 2016 on our Mental Health Reform bill. It actually got included in the 21st Century Cures. One thing we really were interested in was what you are calling the collaborative care model. As I would tell folks, my gosh, the diabetic is psychotic, but the primary care doctor cannot walk the patient down to the psychiatrist or the—you know, and you can go back and forth either way on that.

In your experience in Texas, what makes the collaborative care model so effective in terms of accessing mental health and addictive services?

Dr. KELLER. Well, it is a great question, Senator Cassidy. Thanks for asking.

There is really—there are several factors. Let me highlight a couple. One is that the collaborative care model requires measurement-based care; requires universal screening for depression, anxiety; and then following up with symptom measures to see if the medications worked, which unfortunately, over 80 percent of clinical settings do not do. So, having accountability around symptoms, just like we do for blood pressure, just like we—it is the sixth vital sign, and we need to add it in.

The second thing collaborative care does is that the behavioral health specialist works for the primary care practitioner. It is not a matter like in, you know, when someone sends me a referral as a psychologist, I can make a decision, do I want to see this person? Do they really fit my practice?

If I work for—it is just like the nurse who works for my primary care doctor. When my doctor asks the nurse to take my blood pressure, he does. And then when she asks the primary care provider—I mean the behavioral health specialist in the collaborative care model to follow-up on my depression, he does. So, working within a team-based model is critical.

The practical thing about why collaborative care is so helpful is that it is almost universally covered now, and a lot of folks do not know this because this happened in the last couple years. Medicare added coverage for that in 2017. By the end of 2019, nearly every commercial coverage had added it. We only have about 19 state Medicaid programs. We are about to add Texas. And if we are adding Texas, we would think everybody else should be adding that, as well.

[Laughter.]

Dr. KELLER. We are going to be covering that in every—and that is so—so that makes the work now so much easier than when you looked at this in the Cures Act. Because all we really need you to do is provide startup grants to accelerate the change that eventually will happen. But, if we can do it sooner than 10 years, we are going to save hundreds of thousands of lives.

Senator CASSIDY. A couple of things. I like the way that you phrase this in terms of a business model. Most folks in DC do not understand that your practicing physician, your you-name-it, has to have a business model which works. And, in this case, you have a parallel aspect to the practice, in itself generating revenue to pay for the resource in a way which expands the service and gives better follow-up. So, the business model, we just have to focus on. So, it kind of leads me to my next question.

If we have payment for this already built into various payors, why would grants be required? If I am an FP, I am already having a physician extender check on the blood pressure and do pap smears and, on and on. Those things are time consuming but do not require, cognitive sort of, oh, my gosh, this is a very complicated hypertension.

Similarly, screening for depression and that sort of follow-up is now covered with this sort of payment mechanism. Why are grants required?

Dr. KELLER. Well, I will just—the same business facts that we talked about earlier, Senator. One is that I guess mental health folks are not as good a negotiator for rates as cardiologists are and orthopedic surgeons are. Because you can set up a cath lab to add in additional heart patients. You are going to make money because the rates pay so well.

That is not this case for collaborative care. Collaborative care, the rates cover the costs. They do not cover—there is not a profit margin built in. They just—they are just a little bit more than the cost.

Senator CASSIDY. The reason I say that is because there are business models within the primary care setting in which you do have just like the cardiologist has—somebody over here running the treadmill and someone here doing the echo and someone here doing the prothrombin time, and he or she is basically supervising, but all of them are bringing in revenue. Here, you have the primary care physician monitoring, but you have the same sort of parallel activity that just seems like it defrays your overall expense. And I say this not to challenge, but just to explore.

Dr. KELLER. No, I appreciate that. It covers the ongoing expenses, not the startup costs. You have to hire that person and bring them in, get them up to speed, train them. You have to make technology changes.

That is the biggest barrier in health systems is the technology changes, adding in that measurement into the electronic health records, making sure it is done correctly. And you cannot just—you have to pay—each health system has to pay Epic, Cerner, whoever. It would be great, actually, if you required all the electronic healthcare providers to add this to their systems. But, each system has to do that independently.

There are startup costs that get in the way, and they are a huge barrier. And we found in Texas that if we cover those startup costs, health systems will commit, and then it creates a virtuous cycle where, once you get those initial costs done, those ongoing reimbursement allows you to then spread throughout the entire health system over time.

Senator CASSIDY. Madam Chair, my time is up. But, I will add that I do think electronic health records are under our jurisdiction, and, so, if Dr. Keller gives us a good suggestion, I am open to your leadership. Thank you.

The CHAIR. Good. Well, if it is not, we will expand our jurisdiction, so——

[Laughter.]

The CHAIR. Senator Hassan.

Senator HASSAN. Well, thank you, Madam Chair, to you and the Ranking Member. I thank you for this hearing.

I just also want to echo what Senator Kaine said about the behavioral health challenges of all of our first responders, not just in healthcare. I have been hearing the same thing from police and fire fighters and EMTs in New Hampshire. Among other things, a number of them have just said to me they have not had a day off in a year. And anybody who has not had a day off in a year is going to be struggling with some challenges, so I look forward to addressing that issue.

I wanted to start with—it is a distinguished panel and I am grateful to all of you for your work. I wanted to start with a question to Dr. Muther. Earlier this year, I re-introduced bipartisan legislation with Senator Murkowski, which would expand access to medication-assisted treatment for those struggling with opioid use disorder by eliminating the outdated waiver requirement that keeps many providers from prescribing medication-assisted treatment to their patients.

Yesterday, the Biden administration announced steps to remove some of the burdensome training requirements that practitioners

must meet before they can prescribe medication-assisted treatment. But, there are additional steps that Congress must take to eliminate all of the existing barriers and to ensure access to opioid use disorder treatment for those who need it.

Dr. Muther, you have spoken in the past about the importance of medication-assisted treatment and the myths that contribute to the barriers individuals face when they are trying to access this treatment. How do we fully address these challenges and expand access to medication-assisted treatment during the pandemic and beyond?

Dr. MUTHER. Wow, thank you so much for the question. That is a big question. I think considerations for the medical providers and how we can expand the workforce to have clinical availability, not only for the medical prescribers, but also for the behavioral health specialists, as I have mentioned. We are in no—we are facing workforce shortage, and, so, if we do not have clinicians available and if we do not have clinicians working in the right places, we are never going to meet the need.

There are so many other barriers to care that I have mentioned for patients, as well. And, so, stigma has been touched on. There is the logistical and transportation—logistical barriers, such as transportation, conflicts, work conflicts, and so forth. So, we need to eliminate the barriers to care and make care accessible.

One thing that we have done is, right at the start of the pandemic was related to home-based inductions and developing rapport with patients and building trust so that we can do home-based inductions, for example, safely and effectively. So——

There is also tons of room—I think 95 percent of our encounters at Salud by behavioral health clinician have been done via telehealth. And, that is not only as effective; in many ways, seems to be more effective in meeting the needs of that population. So, it is really about eliminating barriers to care, building the workforce, and building that rapport with the patient community.

Senator HASSAN. Thank you. I appreciate that very much.

Let me move on to a question to Dr. Benton because I want to turn now to another devastating public health crisis that we have talked a little bit about this morning and that Congress has to work to address, which is the issue of youth suicide.

In 2017, Martha Dickey from Boscawen, New Hampshire was traveling for work when she received a phone call that is every parent's worst nightmare. Her 19-year old son, Jason, had died by suicide. After experiencing that unimaginable loss, Martha joined a network of Granite Staters dedicated to suicide prevention and awareness efforts. Advocates, including a local non-profit, the Connor's Climb Foundation, who have worked tirelessly to raise awareness, increase education efforts, and reduce the stigma associated with suicide.

To help build on the brave efforts of these Granite Staters, I am working to introduce bipartisan legislation that would work to expand access to suicide awareness and prevention training for students.

Dr. Benton, can you speak to the importance of providing kids and teenagers with the tools that they need to recognize if they or someone they know is at increased risk of suicide?

Dr. BENTON. Thank you for that question, Senator Hassan. You have asked such an important question.

Most of the time, as you know, young people speak to their peers about their suicidal feelings. So, as much as we discourage young people from going to their peers and asking them to speak with trusted adults, it is not usually the pathway that is taken by most young people. And young people in those situations will tell you that they do not know what to say and they do not know what to do when their peers and their classmates tell them, I feel like killing myself.

We have seen tremendous success with peer counselors who work with suicidal youth. But, the training is absolutely essential. Training youngsters to know how to respond is essential. Providing opportunities for identification of suicidal youth in all community settings is essential.

In the primary care setting, in the schools, by school counselors, in communities, communities' religious organizations, making that training available in one of its many forms—because there are many training opportunities out there—could save lives. We know that for young people who have suicidal feelings, most of them, more than 50 percent, have seen a primary care provider within the week before the time they make the attempt.

There are many opportunities to just ask someone the questions, to get comfortable with knowing what to say, understanding that asking a question about suicide will not make that person suicidal is essential to suicide prevention.

As you referenced, the suicide rates for young people have continued to increase. This year, there were some—there was data suggesting that suicide rates had decreased nationally, but we have not separated that data for young people versus adults. And, what we are seeing on the ground is increasing numbers of young people presenting to emergency departments with suicidal ideation. And I a hundred percent support your assertion that we have to have a public health approach to this problem. That is the way we will end suicide.

Senator HASSAN. Thank you very much.

Thank you, Madam Chair.

Dr. BENTON. Thank you.

The CHAIR. Thank you so much.

Senator Braun.

Senator BRAUN. Thank you, Madam Chair.

During the COVID challenge, many prisoners were released early due to overcrowding, and they are more apt, when they are released, to—since they lose some tolerance to opioids and drugs, have a very, very high rate of overdose and a lot of times, death.

Senator Baldwin and I introduced the Medicare Reentry Act, which would try to get the treatment started prior to when you leave prison. COVID just kind of accentuated the number of cases.

I would like each witness to comment on do you think that makes sense? Is that going to be an effective tool to try to prevent the tragedy of overdose when you finally are released? It seems like it should make sense simply because we had kind of a sad test case through COVID. Start with Dr. Keller, and then the rest of the witnesses.

Dr. KELLER. Well, thank you, Senator, and that is—we do applaud that, the Reentry Act. And I think Ms. Goldsby can probably give more specifics on overdose given her experience. But, I will tell you that it really applies across the board. That coverage—and getting rid of the artificial barrier that says just because somebody is incarcerated, we cannot provide access to their healthcare benefits. I mean, those are outdated things from the 60's. We need to get rid of those barriers and just recognize that there is a practical issue around coordination that we need to do, and it certainly can help with addiction.

There are other things we will need to do, too, to make the care more available once they get out, but certainly the coverage is essential.

Senator BRAUN. Thank you. It is actually the Medicaid Reentry Act. Go ahead with the other witnesses.

Ms. GOLDSBY. Yes, Senator, we agree that it would be very beneficial for Medicaid coverage to extend to cover 30 days prior to release. In South Carolina, we do a lot with overdose education and naloxone distribution for our inmates prior to reentry.

We actually have peer support specialists working in our Department of Corrections to coordinate their reentry, equip them with naloxone, initiate them with medical providers in the prisons, and continue that care with medication-assisted treatment when they need it in an outpatient setting. Our peer support specialists work to get them into recovery residences around the state, back to where they are going, and we hope to expand that work with a supplement to the block grant that this Committee has supported. We hope to expand that work to more than 200 jails in our state as we continue with that overdose education and naloxone distribution to more local settings.

Dr. MUTHER. Well, I will echo my colleagues. And not only is it important for individuals experiencing substance use disorder; it is important for all individuals with all psychiatric medications.

There was a question before from Ranking Member Burr on the comprehensiveness of attribution and is that a good idea, and I mentioned that it is not without challenges. We see this in primary care all the time when people show up and they are out of their medications and they need help. And there are other points of entry and other points of service that they need to get to, each of which runs the risk of that individual falling through the cracks. So, I echo my colleagues' yes and would be supportive of this.

Dr. BENTON. I [inaudible] my colleagues' comments.

Senator BRAUN. Thank you. I had another question on telehealth, but I think it has already been covered. I will yield the balance of my time.

The CHAIR. Thank you.

Senator Murphy.

Senator MURPHY. Thank you very much, Madam Chair.

Thank you all for the great work that you do and spending time with us this morning.

Dr. Benton, I want to thank you for drawing attention in your testimony to the Temporary Reciprocity to Ensure Access to Treatment Act. This is the TREAT Act. Senator Blunt and I have been working on this together. And I will be honest, I continue to hear

from providers about the difficulties that they have treating their patients because of the patchwork of state licensing requirements.

In my state, I recently heard from a college that has effectively had to stop treating their students from out of state because of just the enormous workload connected with tracking state rules and expiration dates. It just became ultimately unmanageable.

I just wanted to ask you to spend a little bit more time on why you referenced the TREAT Act and what barriers that you have experienced during COVID response related to these licensing requirements. And, how might, at the very least, a temporary lifting of that requirement help us in the work that we do around recovery?

Dr. BENTON. Well, thank you, Senator Murphy, for that question. Initially, during the pandemic, as we started to work on pivoting to telehealth as most practices were limited, we experienced delays related to clarification around licensing requirements, so that if you were a practitioner in the state of Pennsylvania, you actually could not see your patients in New Jersey.

Fortunately, legislators responded quickly to address some of those barriers, and the flexibility imposed by those temporary restrictions was really remarkable. We were able to start to practice at least in our immediate tri-state areas, which included Delaware and New Jersey.

What it did not do was address those young people who were in colleges in other states who needed continued treatment. And, so, it—they became significant barriers. In our region, not very far away, there are states where there are very limited numbers of mental health providers, and so it is essential that individuals be able to reach across state lines.

Then, for other populations, for some of our families, they drive several hours to come in for a one-hour appointment, and the flexibility to be able to reach them in their home would expand access. That is especially true for rural and minoritized populations of individuals needing care.

The flexibilities that were permitted during the pandemic are essential for us to be able to provide services. There were unintended benefits of telehealth, including the opportunity to work with families. So, with young people, the 9-year olds cannot drive themselves to their appointments, even though some of them think that they can. But, their parents have to come with them. And, the reality is that their parents are able to engage in treatment now without the long trips. So, we are able to work with entire families in the treatment.

The other barrier is that about 50 percent of young people are covered by Medicaid, and most of the telehealth coverage occurs through Medicare. So, there are some young people who are not eligible.

Maintaining the flexibilities that we experienced through the pandemic would allow us to reach more children and empower families to support the mental health of their children by partnering with the providers.

Senator MURPHY. Great. Well, I appreciate that. And again, I will just, be clear. The TREAT Act is really specific to the pandemic. It is an emergency. We should treat it like one.

Dr. Muther, one additional question for you. In Connecticut, so many of our community health centers are engaged with schools in school-based health centers, and schools are going to find themselves with additional funding over the next year to respond to the pandemic. And I wanted to just ask for your recommendation and thoughts about whether they should be spending that money to build new school-based health centers, supplement existing health centers, or whether we should be pursuing a model where we are just making sure that there is community services for all of these kids.

I have always worried—our school-based health centers are fantastic in Connecticut, but it is really arbitrary whether you have one or you do not. There are plenty of low-income communities in Connecticut that have no school-based health center, and, so, I sometimes worry that we sort of have made a decision not to build the system either inside the school or outside the school. We have a little bit of both.

What is your sort of thought on what schools—how schools should approach using this money for school-based services versus community-based services?

Dr. BENTON. I would have to say that the immediate big demands for schools are generally local, so they have a pretty good sense of what their communities are like. But, what we do know is that school-based mental health services support like 15 to 20 percent of children in the United States, and it is a good way for families and children to receive their care because children are there every day in their communities, and schools are important connections for families.

School-based mental health is a very effective way to reach children and engage families. And, if there are opportunities to systematize that in a way that is accessible to everyone, it would help us with identification of mental health concerns early. It would allow us to participate in a public health approach to prevention so that things do not become crisis and young people end up in our emergency departments.

I would definitely support initiatives that supported the expansion of school-based mental health in all school communities. That could support the young people in our Nation.

Senator MURPHY. Thank you, Madam Chair.

The CHAIR. Thank you very much.

Senator Tuberville.

Senator TUBERVILLE. Thank you, Madam Chair.

This has been interesting. I have enjoyed this. Thank you very much. I have been a mental health coach all my life. Most of you probably know I coached and taught for the last 40 years. And I thought I was a football coach, but I turned into a mental health coach for the last 10, 12 years.

I do not think even my colleagues here really understand the problem that we are having, and it is getting worse in our communities, in our schools. And I want to thank you all for your help and what you do. It is hard. It really is.

It is great to hear the identification part. You have to be able to identify a problem before you can solve it, and we have so many problems. I did, my staff did, our medical staff did.

The problem that I see coming, we are not going to be able to print enough money to pay for mental health programs in the future, No. 1, if we do not do something about our border. We have drugs coming across the border that is unbelievable. And it is amazing to me that we continue to talk about problems, and then we do not stop the occurrence of problems that are the main problem to begin with.

But, it starts with family. Seventy percent of minorities that I coached had one or no parent. And I think a lot of you would agree with that, it starts in the nuclear family, and we are still trying to tear that down. But, there is a lot of things that we can address, but it all goes back just to identification and understanding the problems that we are having in terms of addiction.

I see one of the addictions that we have—and I hope some of you would agree with this. We have alcohol. We have drugs. Social media addiction was absolutely a huge problem on the kids that I coached. Huge problem, because they were addicted to it. They were bullying. There were problems that we had to face every day, and I had to put special rules in for social media.

But, that being said, I wanted to tell you a little bit about something we are doing in Alabama that is actually working. And we got a problem, and we are trying to solve it. We basically took our money in Alabama and we said what we are doing is not working. And, so, we started a broader area, and it was a——

The mental health problem was just going over the top, so we took our mental health and we set it up in the crisis centers all over the state, different regions. And we included the EMS. We included our law enforcement. We included the teachers and everybody in the area. And what we did is we identified the kids or the adults that had mental problems or addiction problems, and we got them to those crisis centers, and it was somewhere that they were away from their classmates, because sometimes you cannot work if you are close to the classmates. They are embarrassed. They will not go. And Alabama is making a huge, huge step forward in our mental health problem. Now, it is not the answer.

But, I want to ask some of you, what can be done on the Federal level to incentivize programs like this to help? Ms. Goldsby, what do you think?

Ms. GOLDSBY. Senator, it is an excellent question, and I think we can look to prevention as an answer. The Substance Abuse Prevention and Treatment Block Grant through SAMHSA supports states in, disseminating evidence-based prevention work. And we do this with our communities by supporting coalitions that use this strategic prevention framework to work with stakeholders at the local level to build protective factors and reduce risk factors to protect our kids so that we are not letting them escalate to crisis.

To your point, Senator, that takes parents, that takes school districts, that takes coaches, that takes, law enforcement, and our healthcare leaders to address the local needs for our children. And, so, we just want to say again that the Substance Abuse Prevention and Treatment Block Grant is a huge support for that work in our state and in others states.

Senator TUBERVILLE. Yes. I started noticing more and more in the last 10 years, we were giving out more drugs, way too many

drugs, to our kids for attention deficit, anxiety. I actually had to intervene with kids that were bringing drugs from their hometowns to our college campuses and giving it to our doctors to make sure that they were giving it out properly. A lot of these kids do not take it properly, and it needs to be a better regimen of how to do that.

But, I want to thank you again. I do not have another question. Just thank you for what you are doing. Again, it is about money, but at the end of the day, it comes down to people, and we need more people in education that get into mental health. And if we do not do that, we are not going to have enough people to be able to answer these problems as they arise down the road because they are going to get worse and worse. So, thank you very much for what you do and for being here today. Thank you.

The CHAIR. Thank you.

Senator Smith.

Senator SMITH. Thank you so much, Chair Murray, and all of you for this testimony today. I think that we are touching on the trauma and the devastation, really, that so many Americans have experienced due to this pandemic. Unprecedented levels of loneliness and grief and anxiety that have been exacerbated by what everybody has been going through. And, so, I just really appreciate Chair Murray and Ranking Member Burr that you are focusing our attention on this today.

I would like to start with Dr. Muther and talk a little bit about the challenges that access to mental healthcare services, behavioral healthcare services in rural parts of the Country.

We have the Sawtooth Mountain Clinic in Minnesota. It is a federally qualified health center located in Grand Marais, Minnesota. The Sawtooth Mountain Clinic has only two full-time independently licensed mental health providers for all of Cook County. Cook County is right up in the far northeastern part of Minnesota. It is 3,340 square miles, so roughly the size of Delaware. Two full-time independently licensed providers there.

In 2020, they saw 253 patients through about 1,100 visits. But, it was so clear that the demand was so much higher, especially, given what was happening, and they are just so concerned that they do not have the resources and the capacity to meet the need that is there.

I am wondering, Dr. Muther, if you could just talk a little bit about what can we do. What have you seen? What do we need to do to support access to mental healthcare and behavioral healthcare, especially with the challenges serving in our rural areas, small towns, and rural places?

Dr. MUTHER. Well, thank you so much for that question. I know Sawtooth is another community health center.

Senator SMITH. Yes, it is.

Dr. MUTHER. The challenges are immense. And, I think when we talk about rural communities, of course we have to talk about broadband and extending internet access, but also cell phone service. And, as has been mentioned, the audio-only, phone call only to, say, landlines in order to reach patients is critically important.

From a clinical perspective, I know they are stretched thin and the numbers that you showed bear out that, again, we clearly do not have enough clinicians to meet the need.

As has been mentioned, the collaborative care model and any type of consultation availability with specialty mental health providers, not only psychiatrists, but psychiatric nurse practitioners and other clinicians with expertise.

If there is any kind of specialty mental health system, say, a community mental health center, how can they partner with those agencies to, again, develop and expand or—and ensure for the entire community collectively and in partnership, is there an entire continuum of behavioral health services.

I might also mention what is commonly known as the ECHO model——

Senator SMITH. Yes.

Dr. MUTHER [continuing]. And share training for any type of—this has been expanded to address a multitude of medical conditions for primary care medical providers, but certainly has been expanded to behavioral health. And, so, the ECHO models in terms of shared learning, shared training, and providing that shared expertise to those clinicians, albeit a limited number of them, is a great way to have an impact.

Senator SMITH. I appreciate you bringing up the ECHO model. We have some great examples of ECHO model implementation in Minnesota, also, and it gets at that collaborative model that is so important.

I also appreciate you talking about a continuum of care because, in addition to a real shortage of access to mental healthcare services, there is a terrible shortage of inpatient beds. And this is a particular challenge—it is a challenge everywhere and for everyone, but especially for youth. And I do not ever want to have to talk again to a parent who is so traumatized by having their child have to go, hours and hours and hours away, if they can go at all, and that child ends up—child or youth ends up sort of stuck either in a hospital bed; or even worse, if they have had an interaction with law enforcement, stuck in a county jail or, where there is no access for them to get help. And that is really traumatizing.

I appreciate the testimony earlier today at the beginning about your experience with that, also, Doctor, and how terrible that can be.

Chair Murray, I know I am out of time. I want to just note one thing, which is I know there have also been some successes with mobile crisis units that have been able to do—kind of connect between emergency room calls and then having a mobile crisis intervention in that moment, which is also another strategy that has been used in Virginia, Minnesota. They are calling it the CAHOOTS model, and I believe that it is based on other efforts in other parts of the Country to get that kind of early intervention when somebody is in crisis, and that is another thing that we could do.

Thank you, Chair Murray.

The CHAIR. Thank you.

Senator Rosen.

Senator ROSEN. Well, thank you, Chair Murray, Ranking Member Burr. I appreciate this really important hearing today because, as so many of my colleagues have been asking and your thoughtful answers on this mental healthcare is critical for our students.

In Nevada, our K through—well, all across the Country, but our K through 12 students, they have suffered some of the worst outcomes over the course of the pandemic. Tragically, in Nevada, Clark County, Clark County School District, has had 19 students, 19, take their own lives since March 2020. They have—CCSD, they have conducted more than 4,300 virtual wellness checks, more than 1,400 in-person wellness checks to promote student safety, well-being.

But, it is clear that we have to do more to engage students and their parents to help our support staff. Nevada is atop—heading on the top of the list that nobody wants to be on the top of. And, so, I thank you for your thoughtful answers to Senator Murphy's questions and to others. But, I would like to move on to a little bit about trauma training.

My office has heard from Nevada childcare advocates, child welfare advocates, that they are finding particular trouble having people who have done trauma-informed training. And, so, how do you recommend as for boosting the specialized mental health workforce to ensure that our mental health professionals have the training and ongoing training opportunities to assist our children through this trauma-informed lens? Of course, child abuse, a lot of things now with the pandemic, people have suffered, families even, through many more things. What do you think we can do to help you there? Dr. Benton.

Dr. BENTON. Thank you for that question, Senator Rosen.

One of the things that we can do is foster the partnerships that my colleagues have described earlier. So, partnerships between community health agencies, schools, places where—the primary care offices where individuals are trained.

There have been successful models of trauma-informed care training for systems in partnership with the payor agencies or the community agencies who actually have the expertise to provide that training. So, for example, to be explicit, one of the things that is occurring in Pennsylvania is community mental health centers are partnering with a cluster of schools to assure that they are doing trauma-informed care training for teachers, and for families when possible, for school administrators, and we are using that model in many other communities.

For the young people, because they are in schools and because they are in their primary care offices, it is a little bit easier, I think, in some ways to navigate those systems. But, we are actually sharing expertise at the community level so that everyone involved with young people could have that access.

That is so important through this pandemic because for minoritized populations and rural populations who have sustained heavy losses. Many of the young people have experienced loss for the first time. And there was no saying goodbye; there was no rituals. So, it is really important that we get out in front of these interventions.

Senator ROSEN. Now, I agree on the collaborative model, for sure. I would like to talk about this particularly for rural, underserved communities or people who may have other kinds of issues. Audio-only telehealth, I continue to hear from providers across my state that audio-only telehealth has been critical to providing timely access to mental healthcare services. Sometimes it is the only thing they have. And, oftentimes, people—there is a security to be on the phone, maybe not showing their face, maybe not letting you into their home. Maybe they can go to safe space and use a telephone somewhere. So, it is really important that we have the flexibility for this delivery model.

I know I just have a few seconds left. So, for Dr. Muther and then Dr. Keller, what—can you talk about your experience with audio-only telehealth for our rural, our underserved communities, or just in general—but, a lot of people do not have access to broadband, we will throw that in there—how important it is that we retain this for mental health services?

Dr. MUTHER. Yes, that is pretty essential.

Senator ROSEN. Not just——

Dr. MUTHER. Thank you. Thank you for the question. Sorry to cut you off.

Senator ROSEN. No, I was going to tell you to go first.

Dr. MUTHER. Yes, absolutely essential. We have talked about rates, prevalence rates, being on the rise since the onset of the pandemic. The truth is the rates—the suspected rates of prevalence for mental illness and substance use disorders are a gross underestimate, and the reason is we do not ask enough people. And, the reason because of that is we do not have the capacity to ask everyone. Say we do not ask the people who are living in more rural areas. We do not have—ask the people who are—who do not have access to internet. So, that is just one example.

I think the phone-only is absolutely essential for the very, very brief, quick check-in encounters that—I shared our patient story—that are meaningful and not reliant on, say, a traditional, 45-minute, face-to-face, lay on the couch therapy hour. This allows for brief check-ins to see how individuals are doing and monitor follow-ups in a way that is quick, easy, and accessible for both the patient and the provider.

Senator ROSEN. Thank you.

Madam Chair, I know my time has expired. I am not sure if there is someone after me, if you would like Dr. Keller to respond. Otherwise, I can take her questions for the record.

The CHAIR. Okay. Let's take the questions for the record. We do have a few more Senators who have questions.

Senator ROSEN. Thank you.

The CHAIR. Thank you. We will take that for the record.

Senator Lujan.

Senator LUJAN. Thank you, Chair Murray, and also the Ranking Member. Thank you for this important hearing.

I appreciate all the conversation that is taking place surrounding Project ECHO, which we all know is a telementoring program for health professionals developed at the University of New Mexico by Dr. Sanjeev Arora.

Dr. Arora, if you are watching and listening, I want to thank you for transforming people's lives and for developing this important program. It has been an honor to be able to work with you.

I know, Chair Murray, you have also been a staunch supporter of Project ECHO, so thank you so very much.

I want to jump into an area with medically assisted treatment. According to the National Academies of Science, more than 80 percent of the two million people with opioid use disorder are not receiving medication-assisted treatment. I was pleased to see Secretary Becerra issue guidance this morning, removing barriers for qualified practitioners to treat with buprenorphine for opioid use disorder.

Dr. Keller, what policy recommendation would you make to ensure that there is a broad provider network that is adequately trained in medically assisted treatment?

Dr. KELLER. Well, thank you, Senator Lujan, for that question. I mean, I think the best thing you could do is remove all the restrictions. There are no restrictions on the prescription of opioid pain relief. Why would there be restrictions for the exact same providers on the provision of treatment to save the lives of people who could potentially become addicted to those pain killers?

It just—this is the kind of thing—I have got to be a little careful on my language here. When I would explain to my grandmother what I did, because she was often perplexed, and I would say we are doing a study, for example, comparing, these two things, she would say, they pay you money to do comparisons like that?

Because I think it is just common sense that the exact same providers who provide the pain killers could also provide the treatment to prevent death from addiction. So, I just think removing them entirely is—and I understand that there are folks who, promote kind of a gold standard, people deserve better treatment, and I understand that sentiment. But, we cannot let the perfect be the enemy of the very good.

There are decades of research in other countries that have shown that these medications—including buprenorphine—are incredibly safe if done in the right hands. I do not understand why there are any restrictions, frankly.

Senator LUJAN. Thank you for that, Dr. Keller. I certainly agree with you. And I certainly agree that one way we can ensure more patients have access to the treatment they need is by eliminating these outdated requirements for providers who are qualified and willing to provide medication-assisted treatment.

That is why I was proud to work with Congressman Tonko last Congress to introduce the Mainstreaming Addiction Treatment Act, and I look forward to working with Senators Hassan and Murkowski on expanding that access. So, thank you so much for that response.

In my time remaining, peer support is something that I really support. Peer support specialists, I am a big supporter and fan of them. I think they make a positive difference in people's lives.

Dr. Keller, as you deploy peer specialists and community health workers in North Texas to expand your mental and substance use disorder workforce, what benefits do peer support providers bring through their lived experiences? And if you could keep that as con-

cise as you can, because I also want to ask Ms. Goldsby her perspective on some of the work she has done with telehealth peer support.

Dr. KELLER. Well, I think the traditional approach—I mean, the main reason why community health workers are helpful is their lived experience. And it is not just lived experience with mental illness or addiction, which is super helpful, but also lived experience of living alongside people in their communities across, you know, racial, ethnic, other demographics. So, I—it is a wonderful intervention.

The second thing I would just add is we have actually partnered with the Harvard Global Health Program to take an approach that was actually developed in India to equip these community health workers with technology—the same types of telesupports that help other workers be able to be more evidence-based. And I would just add that those technology enablements really add efficacy to those community health workers.

Senator LUJAN. I appreciate that.

Ms. Goldsby, South Carolina supported telehealth through support with reimbursement from grant funding. What are some of the positive results that you observed through this innovative delivery of peer support? And what recommendations would you make to policymakers looking to build on your successful delivery of peer support?

Ms. GOLDSBY. Thank you, Senator Lujan. Everybody in South Carolina has probably heard me say that I would like to see an army of peer support specialists in this state, and we are working to build that army, getting them into many locations across the state.

During the pandemic, we did support peer support specialists' use of telehealth in connection to folks for safe distancing measures. I think we need to see better reimbursement rates in our states. We need to see these paraprofessionals supported at a living wage so that they can continue to be supported by the health systems and health centers that they work and continue to do that good work.

Senator LUJAN. Thank you so much, Representative. I appreciate the work that you do down that way.

Chair Murray, I also just want to join my colleagues who have asked for making permanent access to both video and audio mental, behavioral health services, making that permanent, and also addressing the reimbursement challenges so that way we can make it more useful.

Thank you for the time today, and I yield back.

The CHAIR. Thank you. And I am going to take the prerogative of the Chair and let Dr. Goldsby answer your question on medically—on MAT treatment because that is her specialty. I could see she was—really wanted to answer that and would love to hear your response.

Ms. GOLDSBY. Thank you, Chair. I will answer that from my perspective in South Carolina. And I just want to say we have done a tremendous amount of work with the state opioid response grants to expand capacity for medication-assisted services across the state,

enabling our providers in every county to have that service and have patients be able to access that service.

That being said, I keep a spreadsheet of the over 1,000 prescribers in our state who have the DATA 2000 X waiver, and we cross-check that with our state's prescription monitoring program and the prescriptions of buprenorphine dispensed. We are finding that fewer than 10 percent of our prescribers who can treat with buprenorphine, treat addiction, are actually treating addiction.

I think from our perspective in South Carolina, we know we have some work to do with practice transformation. I think we talked about it earlier. How do we enable these primary care and hospital-based services to transform to address addiction as other chronic diseases, giving prescribers and providers the comfort that they can actually help patients manage addiction, this other chronic illness, just like they help patients manage, you know, their hypertension or diabetes. And I think we have a way to go at that, and it is really based in culture.

The CHAIR. Thank you very much.

Senator Hickenlooper.

[Brief silence.]

The CHAIR. Senator Hickenlooper, I think you are muted.

Senator HICKENLOOPER. I hit the mute. Am I still——

The CHAIR. No.

Senator HICKENLOOPER. I am not muted?

The CHAIR. Now we have you. Go ahead.

Senator HICKENLOOPER. There is—when did we add a delay function to the mute button? That must be new.

Dr. Muther, you said that the expansion of telehealth during the pandemic was a saving grace, but we still have a gap in care because the impact the pandemic has at the same time really, as you have all been saying, exacerbated the crisis of mental health.

How has the increased flexibility to provide more services through telehealth helped you reach more patients more frequently during the pandemic?

Dr. MUTHER. Yes, that is absolutely right, and thank you for the question, Senator.

We have to keep in mind that before the pandemic, the system was really overwhelmed such that the demand for behavioral health services far exceeded our capacity to provide those services. And, as I mentioned, the end result was that over 50 percent of individuals experiencing mental illness—and it is more like 80 percent for individuals with substance use disorders—still do not receive care.

That—despite maintaining productivity and high rates of services, because of telehealth throughout the pandemic, because of the added stressors, that gap has only widened, despite the work and the amazing efforts of our amazing clinicians.

We have our work cut out for us, and we need to get creative. As it relates to telehealth, something that is important to mention—and no-show rates was mentioned before. If I am a clinician seeing eight therapy patients, I might get six to show up in person, whereas I might get all eight to attend a telehealth visit. So, it helps with the no-show rate. But, that is only eight visits per clinician, per day. I think we need to expand telehealth well beyond the

direct service clinical encounters and use smart technologies for brief check-ins, mood assessments, instant messaging between clinician and consumer throughout the week or between sessions, and other kinds of technologies to really broaden and deepen the impact.

To think that only face-to-face or video conference, phone encounter, whatever it is, while that clinician is maintaining the same schedule of only eight patients a day, we are not going to get anywhere, to be totally frank about it. We have to use other technologies, group services and other things that we can do via telehealth in order to broaden the reach.

Senator HICKENLOOPER. Now, that is an excellent point, and I agree completely.

Does anybody else want to add on to that telehealth issue? I think it is a key point.

Dr. BENTON. Yes. Hi. I agree with Dr. Muther a hundred percent. One of the things that we have observed with telehealth is that capacity for families to come in for treatment.

When we think about keeping an appointment, for adults, we just need to get out of work. For parents who need to come in for treatment, they need to get out of work, get their kids out of school, make a ton of arrangements, make a travel. And, if in fact you have a child who is struggling with a pretty significant mental health condition, that car ride can be pretty awful.

Telehealth has allowed us to expand access to families who would not be able to come in, particularly those who cannot make a two-hour car ride in our state.

We have also been able to see more patients at more flexible hours. So, we have been able to use telehealth to see patients overnight in our emergency department, which really expands our access. We can vary hours. We can see people early, and we can see folks late.

It has really given us a lot more flexibility and given families more flexibility.

Dr. KELLER. Senator Hickenlooper——

Dr. MUTHER. Senator, if I may quickly, we would be remiss to not touch on the payment models as it relates to the use of telehealth, as well. So, as I mentioned, the smart technologies and the brief check-ins throughout the week, that is not capable or that is not possible in a fee-for-service model, so we have to explore the global payments that allow the—that afford the clinician the flexibility to provide the service that the individual really needs.

Dr. KELLER. [Continuing].Senator Hickenlooper, if I could just add, I think the primary care transformation process that Ms. Goldsby talked about earlier, about increasing capacity to treat addiction, can also be enabled through telehealth by allowing collaborative care to be delivered virtually, and that certainly works just as well. The V.A. has shown that. Many demonstrations have shown that. So, that is another advantage that I think the telehealth extensions will allow.

Senator HICKENLOOPER. Yes. No, absolutely. That is—what a great answer that was from all of you, and I really appreciate all of your willingness to come and be part of this panel. Anyway, I am out of time, as always is the case.

Madam Chair, I will yield back my time to the Chair.

The CHAIR. Thank you very much.

I will turn it over to Senator Burr for any final questions or comments.

Senator BURR. Thank you, Madam Chair. Let me say to our Members, thank you for a tremendous amount of quality questions today. But, more importantly, to our witnesses, thank you for your very candid and knowledgeable answers.

My takeaway earlier when I started was telehealth, and my closing comment is going to be on that.

One year ago, few, if any, of us thought that today we would actually be vaccinating people around the world for COVID because history taught us it cannot happen that quickly. Technology has been a tremendous force multiplier in healthcare.

But, what we have learned is that until there is a stream to fund the application of that technology, technology will always migrate to areas that have a funding stream, and healthcare has never been an embracer of telehealth. Even though it did get its origins at East Carolina University early on, it is used actively by the Veterans Administration for much of their delivery of care for the single reason that the number one problem that they had was transportation. This eliminated the number one no-show reason for a veteran.

Now we have an opportunity to not only expand the use of telemedicine, but to leverage that application for other technologies that can provide force multipliers in the delivery of healthcare overall.

It is a tremendous benefit for mental health, for substance abuse, but we also have to have the realization that the leverage of technology is going to allow us to do things that today we do not think are possible. And in many ways, shapes, or forms, even for mental health, it is because we just do not know that the technology is available, and we have not tried how to use it yet.

I hope what we are doing is opening the door of opportunity today for new and exciting technological treatments for mental health.

I thank the Chair.

The CHAIR. Thank you, Senator Burr.

I have heard from so many women in my home State of Washington and nationwide about how tough this pandemic has been for them in particular—job loss, more caregiving, having to work and teach their kids at the same time, lack of childcare, all of these impacts, not to mention pregnant or postpartum women who had the additional challenge of trying to access healthcare during a pandemic.

I wanted to ask Dr. Muther and Ms. Goldsby, what has the pandemic taught us about how to improve access to mental health and substance use disorder treatment for women? And I will start with Dr. Muther.

Dr. MUTHER. Well, I—yes. Your question is an important one, and you are exactly right. I mean, the school closures, the caring for older parents, likely, the pregnancy issue, and especially as it relates to pregnancy-related depression is another critical issue. And, so, not providing the mental health, behavioral health part of

the pregnancy care for women during and after pregnancy is a mistake that we can no longer afford to provide—or leave absent.

One of the most profound things that we do as an intervention is to teach pregnant women about parenting skills, about sleep, about feeding routines, about discipline, while that child is in utero. And, we provide resources on coping skills, stress relief, managing mood postpartum.

By managing that mother's stress, with everything going on, we can actually do better to break this generational cycle of trauma. And if we have a meaningful intervention with that mother and have her coping effectively and parenting effectively, she may be less likely to allow her child to have what is called an adverse childhood event, and whereby preventing her child from having negative mental health outcomes themselves.

The CHAIR. Thank you.

Dr. Goldsby.

Ms. GOLDSBY. Chair Murray, thank you for this question. It just so happens I was pregnant and had a baby during 2020 in unique circumstances. I think the NIH has recently come out with some studies suggesting that this year has certainly impacted women differently in terms of their consumption of alcohol and other substances, the consequences of which we may not see for many years to come.

That being said, the SAPT Block Grant, prioritizes how states prioritize pregnant and parenting women as a special population that need topnotch services in terms of quality and immediate services in terms of access. I think as single state agencies, our role is to coordinate the care of those services and the access for those women across our states.

In South Carolina, I have a liaison who works for me but works at the Department of Social Services. Her role is to help us align our policy and our programs so that we are implementing best practices when it comes to our women and families in need of substance use disorder services. What that looks like right now is us working together with many stakeholders—all of our OB-GYNs across the state—to develop what we are calling a plan of safe care.

We have a culture shift in our state that we are working on so that women are not afraid of punitive action. If they are drinking or misusing substances, we want them to still access prenatal care, and we want them to not be afraid to do so.

We want to make sure we have wraparound services and that our OB-GYNs and healthcare providers know what to do when they do have a woman in need of services, and that includes further down the line identifying fetal alcohol spectrum disorder. Of course, we want to get ahead of that, but there is work to do down the road.

All of these things tied together, and that is really, our role in terms of coordinating and supporting those women's needs.

The CHAIR. Thank you very much. I think this is a critical issue we all need to be aware of and focus on. I appreciate those answers.

Finally, let me just say this. The past year has really taught us that we have to be better prepared for the next public health emergency, and improving the healthcare workforce is really a key part

of that. Senator Burr and I are working together on a bipartisan basis to improve workforce programs.

Additionally, I have reintroduced the Public Health Infrastructure Saves Lives Act to really strengthen the Country's ability to address public health crises in the future.

Dr. Benton, let me ask you, how can we support the pediatric mental health workforce so we can better address the mental health needs of our kids?

Dr. BENTON. Thank you, Chair Murray. The loan forgiveness program, I think, will be a major component of that so that—many people who are entering this field cannot afford to enter mental health treatment following any training. So, I think that supporting the loan forgiveness would play a major part.

I think expanding access to educational programs for not just the child psychiatrist, but other community partners, peer specialists, and others. I think it would expand our opportunities to expand the mental health workforce.

But, I think the loan forgiveness is a major component of what we could do to support mental health access.

The CHAIR. Dr. Keller, how does a robust public health infrastructure help us with the issues we have been talking about today?

Dr. KELLER. Well, I think beginning with shoring up our primary care infrastructure I think is one of the most important ways because we—the hallmark of a public health approach is we have to detect illness early, and we have to do everything we can to prevent it. Primary care is the best-positioned part of our system, of our health system, to detect.

Then, I think furthermore, including that public health framework with our schools. That really—when we talked about social, emotional development in schools and a multi-tiered system of supports within schools, it is a public health model that looks at the universal interventions that we can do for every student to prevent bullying, to help them not become bullies, to help them develop in a healthy way their emotions and their cognitive skills.

Then, targeting and be able to provide selected services to students who are at risk, and then really making sure we have quick access. And telehealth, we think, is the best way to do that universally across schools so we get children help as soon as the needs emerge.

I think we have to take that full public health framework and embed it both in primary care and in our public schools so they can leverage that public health infrastructure further.

The CHAIR. Well, thank you.

Dr. Goldsby, how does a robust public health infrastructure help us prevent substance use disorders?

Ms. GOLDSBY. Thank you, Chair Murray. I think, substance use disorders are one of many complex public health issues. And, our response to it collectively is only as good as the infrastructure that we have.

I think we have learned a lot of lessons in the last year about our public health infrastructure. I think probably in each state we have recognized our strengths and weaknesses and where we need to fortify in the moment now and with the supplements that Con-

gress has provided for states so that we have the infrastructure to carry programs and services that will be needed in the future.

I think it comes back collaboration, coordination, and communication, and really strengthening at the state level and at the local level our response with that infrastructure.

The CHAIR. Well, thank you.

That will end our hearing today. And I really want to thank Dr. Muther, Dr. Benton, Director Goldsby, and Dr. Keller for joining us today for really a thoughtful discussion. We appreciated it very much.

This past year has been incredibly hard on a lot of people, and it is clear that we have to take action to make sure our families can get the mental healthcare and the substance use disorder treatment that they need. So, I hope we will be able to work together in a bipartisan way on this.

For any Senators who wish to ask additional questions, questions for the record will be due in 10 business days, on Wednesday, May 12, at 5 p.m. The hearing record will also remain open until then for Members who wish to submit additional material for the record.

This Committee will next meet tomorrow, April 29, at 10:00 a.m. in room 106 of the Dirksen Senate Office Building for a hearing on the nominations of Jennifer Abruzzo to serve as General Counsel of the National Labor Relations Board, and Seema Nanda to serve as Solicitor for the Department of Labor.

With that, thank you again to our witnesses, and this Committee is adjourned.

## ADDITIONAL MATERIAL

BREEN COALITION,
*March 25, 2021.*

Hon. TIM KAINE,
*U.S. Senate,*
*231 Russell Senate Office Building,*
*Washington, DC.*

Hon. TODD YOUNG,
*U.S. Senate,*
*185 Dirksen Senate Office Building,*
*Washington, DC.*

Hon. SUSAN WILD,
*U.S. House of Representatives,*
*1027 Longworth House Office Building,*
*Washington, DC.*

Hon. DAVID MCKINLEY,
*U.S. House of Representatives,*
*2239 Rayburn House Office Building,*
*Washington, DC.*

DEAR SENATORS KAINE AND YOUNG AND REPRESENTATIVES WILD AND MCKINLEY:

On behalf of the undersigned organizations, we would like to thank you for introducing the "Dr. Lorna Breen Health Care Provider Protection Act" (S. 610/H.R. 1667). This bipartisan, bicameral legislation will help reduce and prevent mental and behavioral health conditions, suicide, and burnout, as well as increase access to evidence-based treatment for physicians, medical students, and other health care professionals, especially those who continue to be overwhelmed by the COVID–19 pandemic.

The stigma surrounding mental illness is a well-known barrier to seeking care among the general population, but it can have an even stronger impact among health care professionals. For most physicians and other clinicians, seeking treatment for mental health sparks legitimate fear of resultant loss of licensure, loss of

income, or other meaningful career setbacks as a result of ongoing stigma. Such fears have deterred them from accessing necessary mental health care, leaving many to suffer in silence, or worse. In fact, physicians have a significantly higher risk of dying by suicide than the general public.

Ensuring clinicians can freely seek mental health treatment and services without fear of professional setback means their mental health care needs can be resolved, rather than hidden away and suffered through. Furthermore, optimal clinician mental health is essential to ensuring that patients have a strong and capable health care workforce to provide the care they need and deserve.

To ensure patient access to medically necessary care can be maintained, it is vital that we work to preserve and protect the health of our medical workforce. Your legislation will help establish grants for training health profession students, residents, or health care professionals to reduce and prevent suicide, burnout, substance use disorders, and other mental health conditions; identify and disseminate best practices for reducing and preventing suicide and burnout among health care professionals; establish a national education and awareness campaign to encourage health care workers to seek support and treatment; establish grants for employee education, peer-support programming, and mental and behavioral health treatment; and commission a Federal study into health care professional mental health and burnout, as well as barriers to seeking appropriate care.

Thank you again for your leadership on this important issue and for introducing this legislation. We look forward to working with you to ensure the "Dr. Lorna Breen Health Care Provider Protection Act" is signed into law.

Sincerely,

AMERICAN COLLEGE OF EMERGENCY PHYSICIANS
AMERICAN ACADEMY OF DERMATOLOGY ASSOCIATION
AMERICAN ACADEMY OF FAMILY PHYSICIANS
AMERICAN ACADEMY OF NEUROLOGY
AMERICAN ASSOCIATION OF CHILD AND ADOLESCENT PSYCHIATRY
AMERICAN ASSOCIATION OF CLINICAL UROLOGISTS
AMERICAN ASSOCIATION OF NEUROLOGICAL SURGEONS
AMERICAN ASSOCIATION OF ORTHOPAEDIC SURGEONS
AMERICAN COLLEGE OF CARDIOLOGY
AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS
AMERICAN COLLEGE OF RADIOLOGY
AMERICAN COLLEGE OF RHEUMATOLOGY
AMERICAN COLLEGE OF SURGEONS
AMERICAN FOUNDATION FOR SUICIDE PREVENTION
AMERICAN GASTROENTEROLOGICAL ASSOCIATION
AMERICAN MEDICAL ASSOCIATION
AMERICAN MEDICAL GROUP ASSOCIATION
AMERICAN NURSES ASSOCIATION
AMERICAN OSTEOPATHIC ASSOCIATION
AMERICAN PSYCHIATRIC ASSOCIATION
AMERICAN SOCIETY OF ANESTHESIOLOGISTS
ASSOCIATION FOR CLINICAL ONCOLOGY
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
CONGRESS OF NEUROLOGICAL SURGEONS
DR. LORNA BREEN HEROES' FOUNDATION
EMERGENCY NURSES ASSOCIATION
NATIONAL ALLIANCE ON MENTAL ILLNESS
NATIONAL ASSOCIATION OF SPINE SPECIALISTS
PHYSICIANS ADVOCACY INSTITUTE
RENAL PHYSICIANS ASSOCIATION
SOCIETY FOR VASCULAR SURGERY
THE SOCIETY OF THORACIC SURGEONS

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ACP STATEMENT FOR THE RECORD

The American College of Physicians (ACP) is pleased to submit this statement and offer our views regarding mental health and substance use disorders (SUDs) and how they relate to the public health emergency (PHE) caused by Coronavirus (COVID–19). We greatly appreciate that Chair Murray, Ranking Member Burr, and the Health, Education, Labor, and Pensions (HELP) Committee have convened this hearing, "Examining Our COVID–19 Response: Using Lessons Learned to Address Mental Health and Substance Use Disorders," held on April 28, 2021. Thank you for your commitment to ensuring that clinicians have the opportunity to share their views about the response to the PHE caused by COVID–19 including how we can use the lessons learned during the PHE caused by COVID–19 to improve how the medical community treats patients with mental health and SUDs. Through the experiences of its physicians on the frontlines of furnishing primary care during the COVID–19 pandemic, ACP would like to share its input and recommendations surrounding COVID–19 and mental health and substance use disorders (SUDs), including integrating primary care and behavioral health, expanding the available tools to treat mental health SUDs, and increasing the physician workforce.

The American College of Physicians is the largest medical specialty organization and the second-largest physician membership society in the United States. ACP members include 163,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness. Internal medicine specialists treat many of the patients at greatest risk from COVID–19, including the elderly and patients with pre-existing conditions like diabetes, heart disease and asthma.

**The Pandemic Increased Demand for Mental Health and Substance Use Disorder Services**

Recently, the U.S. Government Accountability Office (GAO) released a report, *Behavioral Health: Patient Access, Provider Claims Payment, and the Effects of the COVID–19 Pandemic*. The purpose of the report was to determine if the need for and access to mental health and SUD services varied as the availability to care diminished during the PHE caused by COVID–19. The report showed several concerning trends. The Centers for Disease Control and Prevention (CDC) found that 38 percent of individuals surveyed reported symptoms of anxiety or depression from April 2020 to February 2021. This was a 27 percent increase from 2019 for the same time period. CDC data found that emergency department visits for overdoses was 26 percent higher and suicide attempts was 36 percent higher for the time period of mid-March through mid-October 2020 when compared to that period during 2019. The Substance Abuse and Mental Health Services Administration (SAMHSA) found that in September 2020 opioid deaths in certain sections of the United States increased anywhere from 25 to 50 percent when compared to the same time during 2019. SAMHSA data also showed that contacts by individuals to the Disaster Distress Helpline increased during the PHE caused by COVID–19 in 2020 over comparable time frames in 2019. For example, between March and August 2020, calls hit a high in April 2020 at almost 10,000 calls, which is an 890 percent increase over April 2019. In August 2020, a survey conducted by the National Council for Behavioral Health's (NCBH), found that over half of their member organizations an increased in demand for their services in the three-month period before the survey. A February 2021 follow-up survey by NCBH discovered that the demand for services had increased by 67 percent. [1] Clearly, the U.S. population has experienced a sharp increase in mental health issues and SUDs during the COVID–19 pandemic.

**Mental Health and Substance Use Disorder Workforce Shortage Made Worse by the COVID–19 Pandemic**

Meanwhile, persistent mental health and SUD workforce shortages from before the pandemic only worsened during the PHE caused by COVID–19. Before the pandemic, the Health Resources and Services Administration (HRSA) found that by 2025, shortages of seven different types of mental health clinicians were anticipated, with shortages of 10,000 and above in some clinician fields of practice. In September 2020, HRSA designated over 5,700 mental health provider shortage areas with 119

[1] U.S. Government Accountability Office. (2021) *Behavioral Health: Patient Access, Provider Claims Payment, and the Effect of the COVID–19 Pandemic*. GAO–21–437R. https://www.gao.gov/assets/gao-21-437r.pdf.

million people living in one of these areas. HRSA estimated that available mental health clinicians in these areas were only adequate enough to meet 27 percent of the need for services.[2] SAMHSA reported that due to a combination of reasons, including laying off of staff and the closure of clinicians that could not sustain themselves financially, led to a decrease in access. In February 2021, NCBH reported that member organizations had decreased staff and services because of the pandemic caused by COVID–19, including 27 percent laying off of staff and 23 percent furloughing staff, resulting in 68 percent of member organizations canceling, rescheduling, or turning away patients.[3] Not unexpectedly, the demand for mental health and SUD services rapidly increased during the PHE caused by COVID–19 while at the same time access to these services diminished.

**Integrate Primary Care and Behavioral Health**

ACP strongly supports the integration of behavioral health care into primary care and encourages its members to address behavioral health issues within the limits of their competencies and resources. Accordingly, ACP supports using the primary care setting as the springboard for addressing both physical and behavioral health care. The basis for using the primary care setting to integrate behavioral health is consistent with the concept of "whole-person" care, which is a foundational element of primary care delivery. It recognizes that physical and behavioral health conditions are intermingled: Many physical health conditions have behavioral health consequences, and many behavioral health conditions are linked to increased risk for physical illnesses. In addition, the primary care practice is currently the entry point and the most common source of care for most persons with behavioral health issues—it is already the de facto center for this care. The degree of medical practice integration can vary, from basic coordination between a primary care physician and behavioral health clinicians, to colocation with a behavioral health clinician practicing in close proximity to the primary care physician, to a truly integrated care approach in which all aspects of care delivered in the primary care setting recognize both the physical and behavioral perspective. For example, the patient-centered medical home (PCMH) has been proposed as an appropriate model to address the integration of primary and behavioral care, highlighting its emphasis on primary care, care coordination, and delivery of care by a team of professionals. The Affordable Care Act incentivized the development of Medicaid health homes, which promote addressing behavioral health issues in the primary care setting. Evidence also shows opportunities in the primary care setting not only to address current behavioral health conditions but also to serve as a platform to promote prevention in at-risk patients or populations and address behavioral health conditions before symptoms can occur in patients.[4]

ACP recommends that public and private health insurance payers, policymakers, and primary care and behavioral health care professionals work to remove payment barriers that impede behavioral health and primary care integration. Stakeholders should also ensure the availability of adequate financial resources to support the practice infrastructure required to effectively provide such care. The barriers to seamless integration of behavioral and primary care are both administrative and financial. Behavioral and physical health care clinicians have a long history of operating in different care silos. The artificial separation of behavioral and physical health care is reflected in many ways. For example, primary care physicians generally lack extensive clinical training in behavioral health, and traditional medical and mental health training models and practice environments are substantially different, which may lead to cultural clashes if they are not thoughtfully integrated.[5]

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[2] U.S. Government Accountability Office. (2021) *Behavioral Health: Patient Access, Provider Claims Payment, and the Effect of the COVID–19 Pandemic*. GAO–21–437R. *https://www.gao.gov/assets/gao-21-437r.pdf*.

[3] U.S. Government Accountability Office. (2021) *Behavioral Health: Patient Access, Provider Claims Payment, and the Effect of the COVID–19 Pandemic*. GAO–21–437R. *https://www.gao.gov/assets/gao-21-437r.pdf*.

[4] Crowley R, Kirschner N; Health and Public Policy Committee of the American College of Physicians. The Integration of Care for Mental Health, Substance Abuse, and Other Behavioral Health Conditions into Primary Care: An American College of Physicians Position Paper. Washington, DC: American College of Physicians, 2015. *https://www.acpjournals.org/doi/pdf/10.7326/M15-0510*.

[5] Crowley R, Kirschner N; Health and Public Policy Committee of the American College of Physicians. The Integration of Care for Mental Health, Substance Abuse, and Other Behavioral Health Conditions into Primary Care: An American College of Physicians Position Paper. Washington, DC: American College of Physicians, 2015. https://www.acpjournals.org/doi/pdf/10.7326/M15-0510.

Even though there are challenges, the evidence shows that integrating behavioral health and primary care leads to improved mental health outcomes, improved physical health, improved quality of life, and lower costs. The available research evidence, while limited, does support the efficacy of this approach.[6] The Behavioral Health Integration (BHI) Collaborative, in which ACP participates, has found that benefits of integration can include promoting long-term value, improved patient satisfaction, and reducing the stigma of mental health issues and SUD.[7] Primary care physicians also support integrated care and report that the integrated care model encourages better communication and coordination among behavioral health and primary care physicians and reduces mental health stigma.[8]

Accordingly, Congress can and should take action to encourage primary care and behavioral health integration. Congress could establish grant programs with adequate funding to incentivize primary care uptake of the various integrated care models. These grants could help defray costs of establishing and delivering integrated primary and behavioral health services. These costs can include but are not limited to, hiring additional staff such as behavioral health managers, contracts with other needed healthcare clinicians such as psychiatrist consultants and behavioral health managers, and purchasing or upgrading software and other resources to provide new services such as more coordinated care. Congress could also encourage additional payment models that potentially facilitate integrated care include bundling payments, partial and full capitation, and even fee-for-service. For example, additional fee-for-service payment codes could be aligned to incentivize integration by establishing payment for behavioral health—primary care consultations, multidiscipline care plan development, and related activities.[9]

ACP also strongly supports increased research to define the most effective and efficient approaches to integrate behavioral health care in the primary care setting and Congress should prioritize research in this area. Although a review of the current literature supports the efficacy of the integration of behavioral health care in the primary care setting, it is limited and filled with many gaps. Substantial research is needed to focus on the efficacy of various models of integration, as well as the diagnostic and treatment interventions most appropriate for use in these models. The following additional factors should be considered within research efforts: specific conditions addressed, populations involved (such as child vs. adult), funding structures, personnel employed, and resources available to the participating practices.[10] Federal research agencies, such as the Agency for Healthcare Research and Quality (AHRQ) are well situated to study the best ways of integrating behavioral health care in the primary care setting and Congress should provide the resources to so.

**Improve Mental Health Parity with Increased Federal Oversight and Enforcement**

One of the barriers to true integrated primary and behavioral health care are the likely instances of noncompliance by insurance plans with mental and SUD coverage parity required by Federal law. While the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires parity for mental health and SUD coverage, state and Federal oversight and compliance

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[6] Crowley R, Kirschner N; Health and Public Policy Committee of the American College of Physicians. The Integration of Care for Mental Health, Substance Abuse, and Other Behavioral Health Conditions into Primary Care: An American College of Physicians Position Paper. Washington, DC: American College of Physicians, 2015. *https://www.acpjournals.org/doi/pdf/10.7326/M150510*.

[7] Behavioral Health Integration Collaborative. Behavioral Health Integration Compendium. American Medical Association, 2020. *https://www.ama-assn.org/system/files/2020-12/bhi-compendium.pdf*.

[8] Crowley R, Kirschner N; Health and Public Policy Committee of the American College of Physicians. The Integration of Care for Mental Health, Substance Abuse, and Other Behavioral Health Conditions into Primary Care: An American College of Physicians Position Paper. Washington, DC: American College of Physicians, 2015. *https://www.acpjournals.org/doi/pdf/10.7326/M15-0510*.

[9] Crowley R, Kirschner N; Health and Public Policy Committee of the American College of Physicians. The Integration of Care for Mental Health, Substance Abuse, and Other Behavioral Health Conditions into Primary Care: An American College of Physicians Position Paper. Washington, DC: American College of Physicians, 2015. *https://www.acpjournals.org/doi/pdf/10.7326/M15-0510*.

[10] Crowley R, Kirschner N; Health and Public Policy Committee of the American College of Physicians. The Integration of Care for Mental Health, Substance Abuse, and Other Behavioral Health Conditions into Primary Care: An American College of Physicians Position Paper. Washington, DC: American College of Physicians, 2015. *https://www.acpjournals.org/doi/pdf/10.7326/M15-0510*.

efforts have been uneven. Unfortunately, according to the GAO, the true nature of the problem of noncompliance with MHPAEA is not well known. [11] While noncompliance violations have been reported, these complaints were relatively small in number and not considered a true snapshot of the magnitude of noncompliance. While the GAO found that insurance-plan compliance with Federal parity law was key to coverage parity, Federal agencies are only aware of a small number of patient complaints and discovered violations of coverage parity law. In addition, the GAO found that when Federal agencies did engage in compliance reviews for coverage parity that there was a high rate of insurance plan violations. This frequency, the GAO determined, could indicate that insurance-plan noncompliance with mental health and SUD coverage parity law could be a common occurrence. [12] In response, the GAO recommended that the Federal Government should determine whether current targeted oversight of compliance efforts are sufficient and effective and then develop better ways in which to enforce MHPAEA as well as attain greater oversight authority if needed. [13] ACP strongly recommends that Federal and state governments, insurance regulators, payers, and other stakeholders address behavioral health insurance coverage gaps that remain barriers to integrated care. This includes strengthening and enforcing relevant nondiscrimination laws, including oversight and compliance efforts by Federal and state agencies. [14]

**Make Naloxone More Available to Prevent Overdoses**

ACP supports funding to distribute naloxone to individuals with opioid use disorder to prevent overdose deaths and train law enforcement and emergency medical personnel in its use. A 2019 CDC report found that not all individuals in need of naloxone are receiving it due to prescribing and dispensing variations across the country. The CDC recommended actions to improve naloxone access such as reducing patient insurance copays, enhancing clinician training and education, and focusing allocation, especially to rural areas. [15] Legal protections (that is, Good Samaritan laws) should continue to be established or refined to encourage use of naloxone and the reporting of opioid overdoses in instances where an individual's life is in danger. A GAO review found that overall state Good Samaritan laws helped in reducing deaths by overdose and that states that enacted such laws have lower rates of opioid overdose deaths when compared to before the law's enactment or to states without these laws at all. [16] Physician standing orders to permit pharmacies to provide naloxone to eligible individuals without a prescription should be explored. Insurance and cost related barriers that limit access to naloxone should also be addressed. As the need for naloxone has grown, so has its price. In response, government representatives and private sector entities have partnered to make bulk purchases of naloxone at substantial discounts for state and local jurisdictions fighting the opioid epidemic. These and other efforts must be accelerated to ensure that naloxone continues to reach those in need. [17]

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[11] U.S. Government Accountability Office. (2019) *Mental Health and Substance Use, State and Federal Oversight of Compliance with Parity Requirements Varies*. GAO–20–150. *https://www.gao.gov/assets/gao-20-150.pdf*.

[12] U.S. Government Accountability Office. (2019) Mental Health and Substance Use, State and Federal Oversight of Compliance with Parity Requirements Varies. GAO–20–150. *https://www.gao.gov/assets/gao-20-150.pdf*.

[13] U.S. Government Accountability Office. (2019) Mental Health and Substance Use, State and Federal Oversight of Compliance with Parity Requirements Varies. GAO–20–150. *https://www.gao.gov/assets/gao-20-150.pdf*.

[14] Crowley R, Kirschner N; Health and Public Policy Committee of the American College of Physicians. The Integration of Care for Mental Health, Substance Abuse, and Other Behavioral Health Conditions into Primary Care: An American College of Physicians Position Paper. Washington, DC: American College of Physicians, 2015. *https://www.acpjournals.org/doi/pdf/10.7326/M15-0510*.

[15] Life-Saving Naloxone from Pharmacies, More dispensing needed despite progress. CDC Vital Signs. Centers for Disease Control and Prevention, August 2019. *https://www.cdc.gov/vitalsigns/naloxone/index.html*.

[16] U.S. Government Accountability Office. (2020) Drug Misuse, Most States Have Good Samaritan Laws and Research Indicates They May Have Positive Effects. *https://www.gao.gov/assets/gao-21-248.pdf*.

[17] Crowley R, Kirschner N, Dunn A, Bornstein S; Health and Public Policy Committee of the American College of Physicians. Health and Public Policy to Facilitate Effective Prevention and Treatment of Substance Use Disorders Involving Illicit and Prescription Drugs: An American College of Physicians Position Paper. Washington, DC: American College of Physicians, 2017. *https://www.acpjournals.org/doi/pdf/10.7326/M16-2953*.

**Expand Medication-Assisted Treatment (MAT) for Physicians**

In order to expand access to medication-assisted treatment (MAT) of opioid use disorders, improved training in the treatment of substance use disorders is necessary, including for buprenorphine-based treatment. Pre-and post-buprenorphine training support and education tools and resources should be made available and widely disseminated to assist physicians in their treatment efforts. Physician support initiatives, such as mentor programs, shadowing experienced providers, and telemedicine, can help improve education and support efforts around substance use treatment.[18] In addition, continued efforts are needed to remove barriers or administrative burdens for physicians to fully take advantage of using MAT to treat their patients, such as eliminating burdensome prior-authorization requirements. These roadblocks can delay or deny needed treatment that utilize already approved medications in the course of MAT to treat SUDs. Several states have already taken action to eliminate or reduce prior authorization requirements for MAT and Congress should explore legislative options on the Federal level.[19]

**Establish a National Prescription Drug Monitoring Program (PDMP)**

ACP reiterates its support for the establishment of a national Prescription Drug Monitoring Program (PDMP). Until such a program is implemented, ACP supports efforts to standardize state PDMPs through the Federal National All Schedules Prescription Electronic Reporting program. The College strongly urges prescribers and dispensers to check PDMPs in their own and neighboring states (as permitted) before writing and filling prescriptions for medications containing controlled substances. All PDMPs should maintain strong protections to ensure confidentiality and privacy. In addition to a national PDMP, ACP strongly encourages Congress to be helpful in this area by requiring efforts to facilitate the use of PDMPs, such as by linking information with electronic medical records and permitting other members of the health care team to consult PDMPs.[20]

**Conduct Research to Implement Effective Public Health Interventions**

ACP believes more Federal research is needed. The effectiveness of public health interventions to combat substance use disorders and associated health problems should be studied further. Public health-based substance use disorder interventions, such as syringe exchange programs (SEPs) and safe injection sites that connect the user with effective treatment programs should be explored and tested. Risky injection drug use habits, such as needle sharing, contribute to the spread of HIV, Hepatitis C virus, and other blood-borne pathogens. Several SEPs have shown the potential to reduce the spread of these diseases. Indeed, the Federal Government has already established and funded Syringe Services Programs (SSPs) through the CDC.[21] These community-based prevention programs have a track record of furnishing much-needed services, such as disposal of sterile syringes, vaccination, testing, infectious disease care, and most critically, SUD treatment.[22] These programs may also connect individuals with other health and social services, as well as referrals to SUD treatment, as mentioned above, prevention supplies, and health screenings. As the opioid epidemic continues to increase the number of people who inject drugs, Federal and state funding should be directed to communities to prevent the spread of blood-borne diseases, such as HIV infection and Hepatitis C, as well as connect people to social and health care services that can provide necessary assistance. Because safe injection facilities have not been extensively tested in the

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[18] Crowley R, Kirschner N, Dunn A, Bornstein S; Health and Public Policy Committee of the American College of Physicians. Health and Public Policy to Facilitate Effective Prevention and Treatment of Substance Use Disorders Involving Illicit and Prescription Drugs: An American College of Physicians Position Paper. Washington, DC: American College of Physicians, 2017. *https://www.acpjournals.org/doi/pdf/10.7326/M16-2953*.

[19] American Medical Association. Opioid Task Force 2019 Progress Report. *https://www.end-opioid-epidemic.org/wp-content/uploads/2019/06/AMA-Opioid-Task-Force-2019-Progress-Report-web-1.pdf*.

[20] Crowley R, Kirschner N, Dunn A, Bornstein S; Health and Public Policy Committee of the American College of Physicians. Health and Public Policy to Facilitate Effective Prevention and Treatment of Substance Use Disorders Involving Illicit and Prescription Drugs: An American College of Physicians Position Paper. Washington, DC: American College of Physicians, 2017. *https://www.acpjournals.org/doi/pdf/10.7326/M16-2953*.

[21] Centers for Disease Control and Prevention. Syringe Services Programs (SSPs) Funding. Accessed at *https://www.cdc.gov/ssp/ssp-funding.html*.

[22] Centers for Disease Control and Prevention. Syringe Services Programs (SSPs) Safety and Effectiveness Summary. Accessed at *https://www.cdc.gov/ssp/syringe-services-programs-summary.html*.

United States, state and local health officials need the resources to conduct pilot tests prior to any possible full implementation. [23]

**Ensure Adequate Physician Workforce to Integrate Behavioral Health and Primary Care**

ACP encourages efforts by Federal and state governments, relevant training programs, and continuing education providers to ensure an adequate workforce to provide for integrated behavioral health care in the primary care setting. Cross-discipline training is needed to prepare behavioral health and primary care physicians to effectively integrate their respective specialties. Primary care physicians need to be trained to screen, manage, and treat common behavioral health conditions, and behavioral health providers need to be trained to understand care for common medical needs. Both sectors need to overcome the operational and cultural barriers that prevent seamless integration. A report from the SAMHSA—HRSA Center for Integrated Health Solutions cited inadequate skills for integrated practices and reluctance to change practice patterns. [24]

The workforce of professionals qualified to treat behavioral health and substance use disorders should be expanded. ACP supports policies to increase the professional workforce engaged in treatment of behavior health and substance use disorder. Loan forgiveness programs, mentoring initiatives, and increased payment may encourage more individuals to train and practice as behavioral health professionals. [25]

Primary care physicians, including internal medicine specialists, continue to serve on the frontlines of patient care during this pandemic with increasing demands placed on them. Funding should be continued and increased for programs and initiatives that work to increase the number of physicians and other health care professionals providing care for all communities, including for racial and ethnic communities historically underserved and disenfranchised. [26] According to the Association of American Medical Colleges (AAMC), before the Coronavirus crisis, estimates were that there would be *a shortage of 21,400 to 55,200 primary care physicians by 2033*. In addition, the Federal Government determined that an additional 14,900 primary care physicians and 6,894 psychiatrists were needed *in 2018* to provide services that would have eliminated a HPSA designation for areas with primary care and mental health shortages. [27] Now, with the closure of many physician practices and near-retirement physicians not returning to the workforce due to COVID–19, it is even more imperative to assist those clinicians serving on the frontlines and increasing the number of future physicians in the pipeline.

For example, many residents and medical students are playing a critical role in responding to the COVID–19 crisis all while they carry an *average debt of over $200,000*. In addition, international medical graduates (IMGs) are currently serving on the frontlines of the U.S. health care system, both under J–1 training and H–1B work visas and in other forms. These physicians serve an integral role in the delivery of health care in the United States. IMGs help to meet a critical workforce need by providing health care for underserved populations in the United States. They are often more willing than their U.S. medical graduate counterparts to prac-

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[23] Crowley R, Kirschner N, Dunn A, Bornstein S; Health and Public Policy Committee of the American College of Physicians. Health and Public Policy to Facilitate Effective Prevention and Treatment of Substance Use Disorders Involving Illicit and Prescription Drugs: An American College of Physicians Position Paper. Washington, DC: American College of Physicians, 2017. *https://www.acpjournals.org/doi/pdf/10.7326/M16-2953*.

[24] Crowley R, Kirschner N; Health and Public Policy Committee of the American College of Physicians. The Integration of Care for Mental Health, Substance Abuse, and Other Behavioral Health Conditions into Primary Care: An American College of Physicians Position Paper. Washington, DC: American College of Physicians, 2015. *https://www.acpjournals.org/doi/pdf/10.7326/M15-0510*.

[25] Crowley R, Kirschner N, Dunn A, Bornstein S; Health and Public Policy Committee of the American College of Physicians. Health and Public Policy to Facilitate Effective Prevention and Treatment of Substance Use Disorders Involving Illicit and Prescription Drugs: An American College of Physicians Position Paper. Washington, DC: American College of Physicians, 2017. *https://www.acpjournals.org/doi/pdf/10.7326/M16-2953*.

[26] Serchen J, Doherty R, Hewett-Abbott G, Atiq O, Hilden D; Health and Public Policy Committee of the American College of Physicians. Understanding and Addressing Disparities and Discrimination Affecting the Health and Health Care of Persons and Populations at Highest Risk: A Position Paper of the American College of Physicians. Philadelphia: American College of Physicians; 2021. *https://www.acponline.org/acp-policy/policies/understanding-discrimination-affecting-health-and-health-care-persons-populations-highest-risk-2021.pdf*.

[27] Prepared for the AAMC by IHS Markit Ltd. The Complexities of Physician Supply and Demand: Projections From 2018 to 2033. Association of American Medical Colleges, June 2020. *https://www.aamc.org/media/45976/download*.

tice in remote, rural areas and in poor underserved urban areas. More must be done to support their vital role in health care delivery in the United States.

ACP supports several pieces of legislation from the 116th and 117th Congresses that should be reintroduced, if applicable, and passed in the current 117th Congress to assist medical graduates and the overall physician workforce as well as address the mental and behavioral health needs of physicians themselves.

- *The Resident Education Deferred Interest Act* (H.R. 1554, 116th Congress) would make it possible for residents to defer interest on their loans.
- *The Conrad State 30 and Physician Access Reauthorization Act* (S. 948, 116th Congress) and *the Healthcare Workforce Resilience Act* (S. 3599, 116th Congress), would help with medical student loan forgiveness and support IMGs and their families by temporarily easing immigration-related restrictions so IMGs and other critical health care workers can enter the U.S. to train in internal medicine residency programs, assist in the fight against COVID–19, and provide a pathway to permanent residency status.
- *The Student Loan Forgiveness for Frontline Health Workers Act* (H.R. 2418, 117th Congress) would assist frontline clinicians as they provide care during the pandemic.
- *The Dr. Lorna Breen Health Care Provider Protection Act* (H.R. 1667/S. 610, 117th Congress) is an important proposal because it aims to prevent and reduce incidences of suicide, mental health conditions, substance use disorders, and long-term stress, sometimes referred to as "burnout" among physicians themselves. Through grants, education, and awareness campaigns, the legislation will help reduce stigma and identify resources for health care clinicians seeking assistance. The legislation also supports research on health care professional mental and behavioral health, including the effect of the COVID–19 pandemic. View ACP's letter of support to the *House* and *Senate* for H.R. 1667 and S. 610.

In addition, ACP was encouraged that bipartisan congressional leaders worked together last year to provide 1,000 new Medicare-supported Graduate Medical Education (GME) positions in the Consolidated Appropriations Act, 2021 (H.R. 133)—the first increase of its kind in nearly 25 years—and that some of those new slots will be prioritized for hospitals that serve Health Professional Shortage Areas (HPSAs).

- ACP now calls on Congress to pass the *Resident Physician Reduction Shortage Act of 2021* (H.R. 2256/S. 834, 117th Congress) which would provide 14,000 new GME positions over 7 years, or 2,000 per year to build on the 1,000 new GME slots mentioned above.
- Congress should also pass the *Opioid Workforce Act of 2021* (S. 1483, 117th Congress). This bill would provide Medicare funding for 1,000 more GME positions over 5 years in hospitals that already have established, or are in the process of establishing, accredited residency programs in addiction medicine, addiction psychiatry, or pain medicine.

ACP also supports other physician and clinician workforce programs and we strongly supported providing $800 million for the National Health Service Corps (NHSC) and $330 million to expand the number of Teaching Health Centers (THC) Graduate Medical Education (GME) sites nationwide and increase the per resident allocation that were enacted in the American Rescue Plan (ARP) Act, H.R. 1319. Indeed, a recent study appearing in the *Annals of Internal Medicine* showed that in counties with fewer primary care physicians (PCP) per population, increases in PCP density would be expected to substantially improve life expectancy.[28] Accordingly, Congress should enact policies that will not only increase the overall number of PCPs, but also ensure that these additional PCPs are located in the communities where they are most needed in order to furnish primary care, behavioral health, and SUD services. Enhanced investments in programs such as the NHSC and THCGME that increase the physician workforce should be sustained after the pandemic caused by COVID–19 has come to an end.

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[28] Sanjay Basu, MD, Ph.D; Russell S. Phillips, MD; Seth A. Berkowitz, MD, MPH. Estimated Effect on Life Expectancy of Alleviating Primary Care Shortages in the United States. Ann Intern Med. 2021. *https://www.acpjournals.org/doi/pdf/10.7326/M20-7381.*

**Conclusion**

We commend you and your colleagues for working in a bipartisan fashion to examine any lessons learned about treating mental health and SUD during the COVID–19 pandemic to improve health outcomes and to develop legislative proposals to combat not only the ongoing Coronavirus crisis—but to address any issues caused by the current pandemic as well as future pandemics. We wish to assist in the HELP Committee's efforts in this area by offering our input and suggestions about ways that Congress and Federal health departments and agencies can intervene through evidence-based policies both now and beyond the PHE. Thank you for consideration of our recommendations that are offered in the spirit of providing the necessary support to physicians and their patients going forward. Please contact Jared Frost, Senior Associate, Legislative Affairs, with any further questions or if you need additional information.

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THE PEW CHARITABLE TRUSTS,
PHILADELPHIA, PA AND, WASHINGTON DC,
*April 28, 2021.*

Hon. PATTY MURRAY, *Madam Chair*,
Hon. RICHARD BURR, *Ranking Member*,
*Senate Committee on Health, Education, Labor, and Pensions,*
*428 Dirksen Senate Office Building,*
*Washington, DC.*

DEAR CHAIR MURRAY AND RANKING MEMBER BURR:

With more than 570,000 Americans lost to COVID–19, we must not forget that before the pandemic, our Nation was already in the midst of an opioid overdose crisis that continues to kill hundreds of Americans each day. While we do not yet know the full impact the pandemic will have on the opioid overdose crisis, provisional data from the Centers for Disease Control and Prevention (CDC) predicts that more than 90,000 people died of an overdose in the 12-month period ending in September 2020, the vast majority involving opioids.[1] This represents a nearly 29 percent increase in 1 year—a staggering and growing death toll is impacting communities from coast to coast. Every state and the District of Columbia has seen overdose deaths rise, and it has accelerated during COVID–19.

Thank you for holding the hearing "Examining Our COVID–19 Response: Using Lessons Learned to Address Mental Health and Substance Use Disorders." This hearing is not only timely, but the lessons learned could have a life-saving impact long after the pandemic.

The Pew Charitable Trusts (Pew) is an independent, nonpartisan research and policy organization. Through its Substance Use Prevention and Treatment Initiative, Pew works with states and at the Federal level to address the Nation's opioid overdose crisis by developing solutions that improve access to timely, comprehensive, evidence-based, and sustainable treatment for opioid use disorder (OUD).

Over the past year, our team has monitored the impact of the COVID–19 pandemic on the U.S. substance use treatment system. The pandemic has underscored the need for policy changes that increase access to life-saving treatment for OUD.

**Eliminate Barriers to Medications for Opioid Use Disorder (MOUD)**

The devastating loss of life from opioid overdose is even more tragic because it is preventable. OUD is a chronic brain disease that, like other chronic diseases, can be successfully treated with medications approved by the Food and Drug Administration (FDA). A conclusive body of research demonstrates that medication for opioid use disorder (MOUD) is the most effective way to treat the disease and substantially reduces mortality from overdoses. Two of the medications approved by FDA to treat OUD—methadone and buprenorphine—have been found to reduce mortality from OUD by up to 50 percent.[2]

Prior to the pandemic, individuals with OUD struggled to get effective care: In 2019, only 18.1 percent of the 1.6 million people aged 12 or older with opioid use

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[1] Ahmad FB, Rossen LM, Sutton P. Provisional drug overdose death counts. National Center for Health Statistics. 2021. *https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm*.

[2] National Academies of Sciences, Engineering, and Medicine. 2019. *Medications for opioid use disorder save lives*. Washington, DC: The National Academies Press. doi: *https://doi.org/10.17226/25310*.

disorder received MOUD. As the pandemic continues to strain the U.S. health care system, it is creating even greater hardships for individuals seeking OUD treatment.

Of the three medications approved by FDA to treat OUD, access to buprenorphine in particular has proven to be critical in response to COVID–19. Unlike opioids commonly prescribed to control pain, buprenorphine has a ceiling effect, meaning that its effects will not increase even with repeated dosing, minimizing the risk of respiratory depression leading to fatal overdose compared to other opioid medications. Prescribing buprenorphine for OUD is no more complex to manage than other chronic conditions treated in primary care and is safe to dispense from a pharmacy and take at home.

During the pandemic, buprenorphine is the only FDA-approved medication for OUD that can be prescribed without an in-person visit to a doctor or treatment facility. While COVID–19 had made this medication even more critical for people experiencing self-isolation and quarantine, outdated Federal regulations continue to limit access to the medication.

Yet despite the relative safety of the drug, Federal rules established by the DATA 2000 Act require practitioners who prescribe buprenorphine to receive additional training, registration, and oversight, as well as obtain an additional waiver (known as the X-waiver) from the Drug Enforcement Administration (DEA). DEA data show that only about 6 percent of American doctors have chosen to obtain an X-waiver, and 2020 HHS Office of Inspector General report found that 40 percent of U.S. counties did not have a single waivered provider who can prescribe buprenorphine.[3] This lack of providers leaves millions of Americans, disproportionately in rural areas, without access to local health care providers who can prescribe this life-saving medication.

On Tuesday, April 27, the Biden Administration announced prescribing guidelines for buprenorphine that go into effect today. These guidelines will exempt eligible practitioners (including physicians and mid-level practitioners) from required training for prescribing buprenorphine to as many as 30 patients. This action signals a significant step forward in expanding access to MOUD. However, the Administration does not have the authority to eliminate the X-waiver in its entirety without legislative action by Congress, and the new policy's prescribing flexibility leaves critical procedural requirements and patient count limitations in place—legislation is still needed to fully ensure that all prescribers can assist OUD patients.

**Pew strongly encourages Congress to pass the Mainstreaming Addiction Treatment Act (S. 445)**. This bipartisan legislation would remove the outdated and burdensome Federal rules established by the DATA 2000 Act that require health care practitioners to obtain a waiver from the DEA before prescribing buprenorphine to treat OUD. As the U.S. health care system is being pushed past its capacity by the pandemic, having regulations in place that further limits OUD treatment to a small minority of physicians can no longer be justified.

### Telehealth for Buprenorphine Initiation

The telehealth regulatory flexibilities during the COVID–19 emergency that allow patients to initiate buprenorphine after a telehealth consultation with a prescriber have expanded access to OUD treatment for people who would otherwise be without care. In particular, audio-only telehealth for buprenorphine initiation has been able to reach people facing economic hardship—like individuals leaving incarceration or experiencing homelessness—or living in areas with inadequate broadband access who are less likely to have technology for audiovisual telehealth visits.[4] Audio-only flexibility is also spurring innovative approaches to engage people in treatment, such as Rhode Island's 24/7 telephone hotline that initiated buprenorphine for 74

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[3] Department of Health and Human Services Office of Inspector General, "Geographic Disparities Affect Access to Buprenorphine Services for Opioid Use Disorder" (2020).

[4] U. Khatri et al., "These Key Telehealth Policy Changes Would Improve Buprenorphine Access While Advancing Health Equity," *Health Affairs* (2020), *https://www.healthaffairs.org/do/10.1377/hblog20200910.498716/full/*. L. Wang et al., "Telemedicine increases access to buprenorphine initiation during the COVID–19 pandemic," *Journal of Substance Abuse Treatment* 124 (2021): 108272, *https://doi.org/10.1016/j.jsat.2020.108272*; M. Harris et al., "Low Barrier Tele-Buprenorphine in the Time of COVID–19: A Case Report," *Journal of Addiction Medicine* 14, no. 4 (2020): e136-e138, *https://doi.org/10.1097/adm.0000000000000682*; R. Tringale and A.M. Subica, "COVID–19 innovations in medication for addiction treatment at a Skid Row syringe exchange," *Journal of Substance Abuse Treatment* 121 (2021): 108181, *https://doi.org/10.1016/j.jsat.2020.108181*.

new patients from mid-April 2020 to mid-November 2020, and linked them to community providers for ongoing care. [5]

As evaluations showing positive outcomes from new telehealth programs continue to emerge, there is still no evidence that in-person visits are more effective than telemedicine visits in improving treatment outcomes or curtailing diversion. [6] In fact, studies show no difference in adverse events or 30-day retention between patients initiating buprenorphine treatment at home compared to in-office, and suggest that patients are less likely to no-show for telehealth appointments versus in-person visits. [7]

Given the transformative impact on access to treatment from these telehealth flexibilities, practitioners and public health experts are concerned about returning to restrictive telehealth regulations once the COVID–19 emergency declaration ends. A recent report by George Washington University's Center for Regulatory Studies found that DEA and the Substance Abuse and Mental Health Services Administration (SAMHSA) jointly have authority to continue allowing practitioners to prescribe buprenorphine without first conducting an in-person medical evaluation. [8] Accordingly, Congress should use its oversight role to encourage the agencies to make this policy permanent.

**Take Home Methadone Dosing**

Though methadone initiation requires an in-person visit, patients have benefited from more flexible take-home policies as a result of the COVID–19 flexibilities that allow state regulatory authorities to request blanket exceptions for patients to be able to take home more medication doses—up to 28 days for "stable" patients and up to 14 days for "less stable" patients—and receive counseling via telehealth. This removes a critical barrier to treatment since most methadone patients must visit an opioid treatment program daily to receive their medication. [9]

Recent data shows that these take-home flexibilities are working: at three North Carolina opioid treatment programs, more than 90 percent of patients received take-home methadone doses versus 68 percent prior to the pandemic, and the programs reported that diversion of the medication was uncommon. [10] In addition, allowing patients to have a take-home supply early in treatment has been shown to increase retention. [11] Accordingly, SAMHSA has emphasized the importance of accommodating take-home policies that promote individualized care and can encourage people to enter into and remain in treatment. [12]

To continue this promising new expansion of methadone treatment post-COVID–19 emergency declaration, Congress should use its oversight role to encourage

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[5] S.A. Clark et al., "Using telehealth to improve buprenorphine access during and after COVID–19: A rapid response initiative in Rhode Island," *Journal of Substance Abuse Treatment* 124 (2021): 108283, *https://doi.org/10.1016/j.jsat.2021.108283*.

[6] L. Wang et al., "Telemedicine increases access to buprenorphine initiation during the COVID–19 pandemic," *Journal of Substance Abuse Treatment* 124 (2021): 108272, *https://doi.org/10.1016/j.jsat.2020.108272*.

[7] N.L. Sohler et al., "Home-Versus Office-Based Buprenorphine Inductions for Opioid-Dependent Patients," *Journal of Substance Abuse Treatment* 38, no. 2 (2010): 153–59, *http://www.sciencedirect.com/science/article/pii/S074054720900124X*. S.A. Clark et al., "Using telehealth to improve buprenorphine access during and after COVID–19: A rapid response initiative in Rhode Island," *Journal of Substance Abuse Treatment* 124 (2021): 108283, *https://doi.org/10.1016/j.jsat.2021.108283*.

[8] Dooley, B. C.E. and Stanley, L.E., "Telemedicine & Initiating Buprenorphine Treatment," February 23, 2021, George Washington University Regulatory Studies Center, *https://regulatorystudies.columbian.gwu.edu/telemedicine-initiating-buprenorphine-treatment*.

[9] Deering, D. E., Sheridan, J., Sellman, J. D., Adamson, S. J., Pooley, S., Robertson, R., & Henderson, C. (2011). Consumer and treatment provider perspectives on reducing barriers to opioid substitution treatment and improving treatment attractiveness. *Addictive behaviors, 36*(6), 636–642.

[10] M.C. Figgatt et al., "Take-Home Dosing Experiences among Persons Receiving Methadone Maintenance Treatment During COVID–19," *Journal of Substance Abuse Treatment* 123 (2021), *https://doi.org/10.1016/j.jsat.2021.108276*.

[11] Kourounis, G., Richards, B. D. W., Kyprianou, E., Symeonidou, E., Malliori, M. M., & Samartzis, L. (2016). Opioid substitution therapy: lowering the treatment thresholds. *Drug and alcohol dependence*, 161, 1–8.

[12] Substance Abuse and Mental Health Services Administration. *Federal Guidelines for Opioid Treatment Programs*. HHS Publication No. (SMA) PEP15-FEDGUIDEOTP. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015. *https://store.samhsa.gov/sites/default/files/d7/priv/pep15-fedguideotp.pdf*.

SAMHSA to make this flexibility permanent, which the agency can do through its statutory authority. [13]

Thank you for your continuing efforts to support expanding access to OUD treatment and for taking swift action to address the coronavirus pandemic. As the Committee's work continues on this issue continues, Pew encourages the Committee to prioritize proposals that increase the availability of comprehensive and evidence-based treatment for OUD and improve care provided to vulnerable populations. Pew welcomes the opportunity to work with you to reduce the human toll related to the opioid crisis.

Sincerely,

ELIZABETH CONNOLLY,
DIRECTOR,
*Substance Use Prevention and Treatment Initiative.*

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[Whereupon, the hearing was adjourned at 12:14 p.m.]

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[13] Dooley, B. C.E. and Stanley, L.E., "Extending Pandemic Flexibilities for Opioid Use Disorder Treatment: Unsupervised Use of Opioid Treatment Medications," April 22, 2021, George Washington University Regulatory Studies Center, *https://regulatorystudies.columbian.gwu.edu/unsupervised-use-opioid-treatment-medications*.