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MENTAL HEALTH AND SUBSTANCE USE DISORDERS: RESPONDING TO THE GROWING CRISIS

HEARING

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

UNITED STATES SENATE

ONE HUNDRED SEVENTEENTH CONGRESS

SECOND SESSION

ON

EXAMINING MENTAL HEALTH AND SUBSTANCE USE DISORDERS: FOCUSING ON RESPONDING TO THE GROWING CRISIS

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C O N T E N T S

STATEMENTS

TUESDAY, FEBRUARY 1, 2022

MENTAL HEALTH AND SUBSTANCE USE DISORDERS: RESPONDING TO THE GROWING CRISIS

Tuesday, February 1, 2022

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

The Committee met, pursuant to notice, at 10:04 a.m., in room G50, Dirksen Senate Office Building, Hon. Patty Murray, Chair of the Committee, presiding.

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

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 growing mental health and substance use disorder crisis.

I will have an opening statement followed by Senator Murkowski, she is standing in for Ranking Member Burr for this hearing, and then we will introduce our witnesses. I believe the Ranking Member will join us a little later as well. After the witnesses give their testimony, Senators will each have 5 minutes for a round of questions.

While we were unable to have the hearing fully opened to the public or media for in-person attendance, live video is 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.

We continue to see a high number of new COVID cases, so we are having this hearing in a larger hearing room where we can be socially distanced, limiting the number of people who are in the hearing room, accommodating both some of our Committee Members and our witnesses through video as we have done previously, and taking additional measures such as wearing masks.

As always, I appreciate the work from the staff of the Sergeant-at-Arms, the Architect of the Capitol, and our Committee Clerk and staff to make this hearing as safe as possible. Thank you to all of you. Even before the COVID–19 pandemic, our Nation was facing mental health and substance use disorder challenges on

multiple fronts. Millions of people experienced depression, anxiety, and other mental health disorders.

Drug overdoses were on the rise, and our health workforce was stretched far too thin. In 2018, mental health issues were responsible for 56 million doctor office visits and 5 million emergency room visits. In 2019, suicide was the second leading cause of death among adolescents. From 1999 to 2019, the rate of overdose deaths more than tripled, and then COVID–19 hit and made things worse.

Our Nation lost over 100,000 people to drug overdoses in a single year, and overdose deaths, especially deaths involving fentanyl, skyrocketed in my home State during this pandemic. Nationwide, we are also seeing a concerning rise in methamphetamine and cocaine use as well. Across the country, people are stressed, and this pandemic has been especially traumatic for children.

Our schools, teachers, and education leaders are seeing this every day. Our educators are on the front lines trying to help so many students experiencing mental health challenges, often without the support of trained mental health professionals. We have seen sharp increases in kids' visits to the emergency room for mental health crises, thoughts of suicide, and suicide attempts, especially among girls. And as of last December, over a 167,000 children have had their world shattered after losing a parent or caregiver to COVID–19, some have even lost both parents. And we know marginalized students are facing the worst of these challenges, deepening inequities they already face. We also know educators and caregivers are facing their own mental health challenges from the strain of this pandemic as well.

We need to continue helping our students and educators and ensuring schools have the support, training, and resources they need. But right now, our mental health and substance use disorder workforce is stretched too thin to meet the needs of our kids, let alone our communities at large. And if we just keep stretching without taking action, something is going to break.

For example, nearly half of psychologists reported feeling burnt out last year, and we aren't even close to providing mental health care to everyone who needs it. Almost 130 million Americans live in areas with less than 1 mental health care provider per 1,000 people. In my home State of Washington, our mental health care workforce is only able to meet 17 percent of our State's needs. Meanwhile, nationwide, less than 1 in 10 people who need treatment for substance use disorder actually get it. And these hardships are not felt equally.

The highest increase in opioid deaths recently has been among Black Americans. Rates of suicide are highest among American Indian and Alaska Native populations, and people with developmental disabilities who are already almost five times more likely to have mental health needs have had their lives upended. Of course, while some communities may face greater behavioral health challenges, this crisis affects all of us.

Even if we aren't personally struggling with mental health or substance use, we all have friends and families who are whether we realize it or not. We all rely on first responders, health care providers, teachers, and other frontline professionals who are facing

burnout and trauma. We all have a stake in making sure people can get the help they need.

That is why Democrats passed the American Rescue Plan to provide resources for schools to hire counselors and psychologists, community based behavioral health providers, programs to treat mental health, suicide, burnout, and substance use, and more. But we are not done. Healing the scars of this pandemic won't be quick or easy. This will take years and we must act accordingly. It is time to build on this Committee's bipartisan history of expanding access to mental health services and responding to rising drug overdose deaths like we did in 2016 and 2018.

In my State, I have seen how communities can benefit from some of the critical programs this Committee has worked on, including programs at the Substance Abuse and Mental Health Services Administration. For example, in Clark County, which saw fentanyl deaths triple in 2020. Lifeline Connections is using a SAMHSA grant to better prepare teachers and school personnel, law enforcement, first responders, and caregivers to respond to mental health crises and refer those in need to appropriate treatment.

Meanwhile, in King County, Federal support has allowed Neighborhood House to provide mental health services for over 150 adults experiencing homelessness. And the Confederated Tribes and Bands of the Yakama Nation are using grant funding from SAMHSA to fight the high rate of suicide in their community by updating their health records and mental health procedures, hiring more therapists, and expanding telehealth services which have been critical to reach people during this pandemic.

If we are going to respond to the behavioral health issues this pandemic has made worse, it is clear we have to build on these efforts. That will take legislative action. So I look forward to hearing from our witnesses about how we can do that and working with Senator Burr and everyone on this Committee on a bipartisan effort to reauthorize, improve, and expand critical Federal programs that address mental health and substance use disorder challenges. I hope that every Member of this Committee and the Senate can work together to bring their priorities forward to us to include.

My goal is to work with Ranking Member Burr to fold these priorities together into a larger package that makes progress on many of the issues that we are going to hear about today, like suicide screening and prevention, youth mental health, the opioids and overdose crisis, and breaking down barriers in access to mental health.

Finally, I want to acknowledge that mental health and substance use disorders do not exist in a vacuum. In addition to this pandemic, there are a lot of issues people are worried about right now, from gun violence to climate change to systemic racism to just making ends meet. As we work to do more to help people struggling with depression, anxiety, and stress, we also need to look for ways to solve the problems that are making things so hard for so many people in the first place.

I hope to continue to work with my colleagues on these root causes as well. I would also like to introduce two letters for the record, one from the American Academy of Pediatrics, the Amer-

ican Academy of Child and Adolescent Psychiatry, and the Children's Hospital Association with recommendations for addressing the National Emergency in Child and Adolescent Mental Health, and the other four members of the American Federation of State, County and Municipal Employees, highlighting the importance of supporting the behavioral health workforce. So ordered.

[The following information was not submitted for the Record:]

The CHAIR. With that, I will turn it over to Senator Murkowski for her opening remarks.

OPENING STATEMENT OF SENATOR MURKOWSKI

Senator MURKOWSKI. Madam Chair, thank you for convening the hearing. I appreciate that. I also want to thank Senator Burr for asking me to substitute in as Ranking Member today on this incredibly, incredibly important and certainly timely conversation as we talk about mental health and substance abuse disorders.

Madam Chair, you have outlined well, I think this statistics the challenges that we are seeing. We knew, we have known for years now that mental health and substance abuse disorders have really been at crisis levels in many parts of the country, certainly in my State of Alaska, and we have seen those challenges and those issues only further compounded by this pandemic. Access across the country, access to mental health and substance use care remains severely limited, exacerbating suicide and substance abuse rates.

You have mentioned the statistics in your State, Madam Chair, with regards to mental health providers and facilities. In Alaska, more than 80 percent of our communities do not have sufficient mental health providers while, again, we are seeing this crisis only continue to elevate, and unfortunately it knows no barrier on the spectrum. We are seeing more and more young kids.

I mean, it used to be when we were talking about suicide statistics, we would look at that 25, 45 year age bracket and now the alarm that we are seeing is in 10, 11, 12 year olds who are suffering, and we have an obligation to hear and to respond. Alaska ranks second in the country for suicide deaths. We have seen a sharp increase in drug overdose deaths, just as we have seen across the country this year. Alaska has one of the highest rates of binge drinking. Suicide rates among members of our armed services have doubled. We have seen some very, very disturbing trends of late.

As we have seen across the Nation, our Native people face shockingly disproportionate rates of mental and behavioral health and substance use disorders and suicide. And these are statistics that keep you up at night, not just because they are numbers, but these are real people. These are our constituents. These are people in our neighborhoods, in our communities. They are people who are in pain.

As we will hear from the young woman, Claire Rhyneer, who will be introduced in just a moment, a youth advocate from Anchorage, Alaska, she urges us, she reminds us that these people that are not statistics, but these real people are looking to us, they are watching, the leaders, waiting for us to do something. And I think the

message of hope needs to be that we are paying attention, that we are listening, and that we are working together to try to address some of the root causes of what we have seen.

I think just within this Committee, we have seen some strong collaboration on efforts. I have been working with Senator Hassan on the Mainstreaming Addiction Treatment Act, which allows health care providers to prescribe buprenorphine, which can truly, truly save, save lives with the medication assisted treatment.

In addition to lifesaving substance use treatment, we know that we have to invest in wraparound recovery services. I have visited programs in Alaska that focus not just on preventing the overdose deaths, but also really building a community for Alaskans in recovery, because that has to be the follow on. We have worked—we have worked on efforts to reduce fetal alcohol syndrome disorders, to address the mental health needs.

Senator Smith and I are leading both the Mental Health Professional Workforce Shortage Loan Repayment Act to bolster our supply of providers, but also to Telemental Health Improvement Act to ensure that insurance covers these critical services. Senator King and Senator Kelly and I are working on the effective suicide screening and assessment in the Emergency Department Act to provide resources for emergency room personnel to identify, assess, and treat individuals at risk of suicide.

I think unfortunately, we know that is where far too many who are seeking help end up sitting in an emergency room where you don't necessarily have those that are trained to identify and assess. Later this week, I am going to be introducing the Guarding Our Mental Health Act to prevent Coast Guard members who seek help for their mental health from being automatically processed for discharge.

Again, we know we have got to make headway on the stigma issues associated with mental health. And then with Senator Rosen, we are going to be introducing the Youth Mental Health and Suicide Prevention Act to ensure that SAMHSA can provide additional mental health programing to elementary, middle, and high school students. So, Madam Chair, I think we know around the Senate here there is plenty that can divide us.

I would like to think that mental health, substance abuse, these are areas where we really can find true bipartisan consensus and hopefully we can build a package that addresses these issues head on. And I commend the work that you have made along with Ranking Member Burr to do just that.

Again, I am looking forward to being able to introduce the Committee to a bright young Alaskan, Claire Rhyneer. And when it is appropriate, I will do that. But thank you, Madam Chair, and I look forward to the testimony from all witnesses today.

The CHAIR. Thank you. We will now introduce today's witnesses. Senator Burr has joined us, so I will turn it over to him to introduce our first witness, Dr. Prinstein.

OPENING STATEMENT OF SENATOR BURR

Senator BURR. Madam Chair, thank you very much for holding this hearing and for the opportunity to introduce Mitch Prinstein to the Committee. Mitch is from Chapel Hill, North Carolina.

Dr. Prinstein is the American Psychological Association Chief Science Officer and responsible for leading the Association's science agenda. Dr. Prinstine also serves as the John Van Seters Distinguished Professor of Psychology and Neuroscience at the University of North Carolina at Chapel Hill.

He began his academic career as an Assistant Professor and later a Director of Clinical Psychology at Yale University Department of Psychology. Dr. Prinstein's research is focused on interpersonal relationships primarily among adolescents, and he has published more than 150 scientific articles and 9 books over the course of his career.

Dr. Prinstein earned his Doctoral and Master's degree from the University of Miami. His bachelor's degree from Emory University. Dr. Prinstein, I thank you for being here today and for all your work on behalf of children and families across the Nation and in our great State of North Carolina. Welcome. Thank you, Madam Chair.

The CHAIR. Thank you, Senator Burr. Next, we have Dr. Michelle Durham. Dr. Durham is the Vice Chair of Education in the Department of Psychiatry and a Clinical Associate Professor of Psychiatry and Pediatrics at Boston University School of Medicine and Boston Medical Center. She is a Board certified physician with a background in pediatrics psychiatry, adult psychiatry, and addiction medicine.

Dr. Durham's public health and clinical roles have always been in marginalized community, and she has been a dedicated advocate for equitable mental health treatment. She is also the Director of Clinical Training for Boston Medical Center's Transforming and Expanding Access to Mental Health in Urban Pediatrics, or the TEAM Up initiative. Dr. Durham, so glad that you could join us today.

I look forward to your testimony. Our next witness is Sarah Goldsby. She is the Director of South Carolina Department of Alcohol and Other Drug Abuse Services. She was confirmed to that position by the South Carolina Senate in February 2018 after serving as Acting Director since August 2016.

Director Goldsby has led South Carolina's response to the opioid crisis and serves as co-chair of the State opioid emergency team, meaning she has been on the frontlines of the crisis we are talking about today. In her role, she has helped expand access to naloxone across South Carolina. She also understands the importance of addressing social determinants of health and making sure people have access to care.

Director Goldsby previously came before this Committee last year to discuss mental health and substance use disorder challenges related to the COVID–19 pandemic. Director Goldsby, welcome back. I appreciate your joining us to share your expertise once again. Our next witness is Jennifer Lockman, Ph.D., is the

CEO of the Research Institute at Centerstone in Nashville, Tennessee.

Dr. Lockman oversees all research and program evaluation activities at Centerstone. Her work focuses on developing and testing new interventions to further suicide prevention care. She has been a lead evaluator for multiple Substance Abuse and Mental Health Services Administration grants, focused on suicide prevention in youth and adults, as well as in zero suicide health programs.

Dr. Lockman, thank you for joining us today. I look forward to hearing from you. And finally, I will turn it over to Senator Murkowski once again to introduce our last witness.

Senator MURKOWSKI. Thank you, Madam Chair. I am delighted to be able to introduce to the Committee Claire Rhyneer from Anchorage, Alaska. Claire is an articulate youth advocate. I think she has been able to effectively give voice to so many through storytelling. She has, in this capacity, encouraged others to speak out.

I first came to recognize Claire when her story was printed on the front page of the Anchorage Daily News some months back outlining what she had done as one individual who looked at what was happening around her as a young girl and the lack of availability of services, the questions that she had, and really nowhere to turn but literally the internet.

She had indicated in that article, she says, mental health was just never talked about. It was not talked about in the home. It was not talked about at school. Even in health classes where you would expect to hear it, the discussion was about making sure that you ate the right foods, you got the right sleep, but we don't focus on mental health, and so her advocacy has been one that is truly, truly impressive.

She is a recent graduate of West High School. She is spending her gap year working with the National Alliance on Mental Illness there in Anchorage. She is going to be attending Middlebury College in Vermont this fall.

Claire, thank you not only for being here today and sharing your story, but your advocacy and your voice on behalf of so many. Thank you, Madam Chair.

The CHAIR. Thank you, Senator Murkowski. Ms. Rhyneer, thank you for joining us today to share your story. It is really important that we hear voices like yours about what students are facing, so we appreciate it.

With that, we will begin our witness testimony. Dr. Prinstein, you may begin with your opening statement.

STATEMENT OF MITCH PRINSTEIN, PH.D., ABPP, CHIEF SCIENCE OFFICER, AMERICAN PSYCHOLOGICAL ASSOCIATION, CHAPEL HILL, NC

Mr. PRINSTEIN. Sorry, can you hear?

The CHAIR. Yes, we can.

Mr. PRINSTEIN. Chairwoman Murray, Ranking Member Burr, Senator Murkowski, and Members of the Committee, thank you for the opportunity to testify. I am Dr. Mitch Prinstein, Chief Science Officer of the American Psychological Association.

APA is the largest scientific and professional organization representing psychology in the U.S., with over 130,000 psychological researchers, educators, practitioners, and students. There's been much discussion of a mental health crisis in the U.S.

Today I want to talk briefly about what that crisis looks like. This is an issue that began well before the pandemic, with millions of Americans experiencing emotional and behavioral symptoms that we could have prevented. The U.S. has fared more poorly than most, with the rate of suicide attempts in the United States higher than in any other wealthy Nation on the planet.

There is simply not enough mental health care providers, and there is not enough investment in science to use what we know to prevent mental illness. Today, only one of seven Americans with mental health or substance use disorders is receiving treatment scientifically proven to work. Of course, the COVID–19 pandemic has made this much worse. In 2021 alone, children's hospitals saw a 42 percent increase in self-injury and suicide cases. School principals report that their staff are overwhelmed with children experiencing apathy, hopelessness, anxiety, and thoughts of death.

To say that this is a mental health crisis is not enough. This is an accumulation of decades of neglect, stigma, and unequal treatment of mental health compared to physical health. Now we are at a turning point like we have not seen since World War II, when our country elected to make a serious investment in mental health by building the VA system, investing in mental health workforce, and forming the National Institute of Mental Health. That was over 70 years ago.

The time has come again. Today, we know that bifurcating physical and mental health is based on antiquated notions. It is time to create a mental health system that reflects the 21st century, and we have no time to waste. Here is what you can do immediately to address this national emergency. First, we desperately need a diverse and robust mental health workforce. Today, we have 5,000 psychology trainees who could serve a far greater number of people if Medicare were reimbursed for their work during residency, just as currently occurs for medical residents. This just makes good sense.

Doctoral interns in psychology have an average of over 700 hours of independent direct patient care experience, more than most medical residents, and we can mobilize thousands of mental health care workers quickly. Second, we have the psychological science to deploy preventive interventions through school and community based partnerships.

The Mental Health Services for Students Act and reimbursement for psychologists to guide these partnerships can have multiplier effects, so each member of our current workforce is building resilience with an entire classrooms and schools. Third, we need to expand the integration of primary and behavioral health care because it works, but not with a one size fits all approach. We will need to support all evidence based models and allow primary care providers the flexibility to determine which model best suits their patients' needs.

Fourth, the 2022 Mental Health Parity and Addiction Equity Act Enforcement Report just submitted to Congress indicates that our Federal agencies are struggling. Congress must grant the Department of Labor the authority to assess civil monetary penalties for violations of the law or enforcement will be almost impossible. Now, this will only get us part of the way. We will need long term strategies as well to fix this problem that has been growing for decades. Our country invests $15 billion annually to ensure that we have enough physical health care providers with the appropriate specialties and spread throughout the country, yet we invest less than 1 percent of that amount to build a mental health care workforce.

Congress must authorize, reauthorize and significantly expand the Graduate Psychology Education and Minority Fellowship Programs and enact the Mental Health Professionals Workforce Shortage Loan Repayment Act. It is also critical that we significantly expand our scientific investment in psychological science so we can better understand psychopathology, develop novel treatments, and build resilience before the next stressor occurs.

A $1 billion increase to NIMH and NICHD and NIMHD for youth mental health would still be a very small proportion of the allocation currently offered to study conditions that afflicts far fewer youth than those currently suffering from psychological disorders. Thank you again for the opportunity to speak with you today.

We stand ready to help you with any and all issues dealing with human behavior. We have the expertise to address your Committee's work, and I look forward to answering your questions.

[The prepared statement of Mr. Prinstein follows:]

PREPARED STATEMENT OF MITCH PRINSTEIN

Chairwoman Murray, Ranking Member Burr, and Members of the Health, Education, Labor, and Pensions Committee, thank you for the opportunity to testify today on the on-going mental health and substance use disorder challenges facing Americans. I am Dr. Mitch Prinstein, Chief Science Officer at the American Psychological Association (APA). APA is the Nation's largest scientific and professional organization representing the discipline and profession of psychology, with more than 133,000 members and affiliates who are clinicians, researchers, educators, consultants, and students. Through the application of psychological science and practice, our association's mission is to have a positive impact on critical societal issues.

The COVID–19 pandemic has placed an enormous strain on individuals, families, and communities. Beyond the very real physical ramifications of the virus, the effects of social isolation, disrupted routines, loss of jobs and income, and grief associated with the death of a loved one have caused significant distress and trauma, which typically have downstream effects on mental health. During the pandemic, about four in 10 adults have reported symptoms of anxiety or depressive disorder, an increase from the one in 10 adults who reported these symptoms from January to June 2019.[1] Data also shows a surge in emergency department visits attributable to a mental health crisis, suicide attempts, and in drug overdoses during the COVID pandemic.[2] Additionally, there have been significant increases in unhealthy behaviors, such as eating disorders, sleep disruptions, alcohol consumption, and illicit

[1] Panchal, N., et al. The Implications of COVID–19 for Mental Health and Substance Use. Kaiser Family Foundation. (2021). Retrieved from: *https://www.kff.org/coronavirus-covid–19/issue-brief/the-implications-of-covid–19-for-mental-health-and-substance-use/*

[2] Holland, K. M., Jones, C., Vivolo-Kantor, A. M., et al. (2021). Trends in U.S. Emergency Department Visits for Mental Health, Overdose, and Violence Outcomes Before and During the COVID–19 Pandemic. JAMA Psychiatry, 78(4), 372–379. doi:10.1001/jamapsychiatry.2020.4402

drug use.[3,4,5,6] ven these factors, it is likely that the pandemic's mental and physical health impact will be present for generations to come.

To be clear, the need for greater investment in behavioral health care predated COVID–19. According to results from SAMHSA's 2019 National Survey on Drug Use and Health, 26 percent of U.S. adults with any mental illness had unmet mental health needs during the previous year, and over 47 percent of those with serious mental illness report having unmet needs.[7] However, the pandemic has significantly increased the need for services. A recent APA survey of psychologists shows increased demand across all treatment areas, including anxiety, depression, and trauma-and stress-related disorders.[8] Rates of substance use also grew during COVID–19. According to the Centers for Disease Control (CDC), between June 2020 and June 2021, approximately 100,000 people in the U.S. died from an overdose, which is a substantial increase from the previous year.[9]

One of the more alarming trends exacerbated by the pandemic is the impact on youth mental health, including among children who did not previously exhibit symptoms of a behavioral health disorder.[10] The mental health of children is frequently tied to the overall health, safety, and stability of their surroundings. Ongoing national surveys of households with young children have found high levels of childhood hunger, emotional distress among parents, and frequent disruptions in child-care services.[11]

Recent data show that nearly 10 percent of U.S. children lived with someone who was mentally ill or severely depressed.[12] Furthermore, since the start of the pandemic, over 167,000 children have lost a parent or caregiver to the virus.[13] This kind of profound loss can have significant impacts on the mental health of children, leading to anxiety, depression, trauma, and stress-related conditions.

Increases in demand for pediatric inpatient mental health services are also a particularly concerning indicator. Between April and October 2020, the proportion of children between the ages of 5 and 11 and adolescents ages 12 to 17 visiting an emergency room due to a mental health crisis increased by 24 percent and 31 per-

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[3] University of Minnesota Medical School. (2021, April 12). COVID–19 pandemic has been linked with six unhealthy eating behaviors: Study shows a slight increase in eating disorders, one of the deadliest psychiatric health concerns ScienceDaily Retrieved from *www.sciencedaily.com/releases/2021/04/210412114740—htm*

[4] Bean, S. R., Khawaja, I. S., Ventimiglia, J. B., & Khan, S. S. (2021, December 1). COVIDsomnia: Sleep Disruptions Associated with the COVID–19 Pandemic. Psychiatric Annals 51(12), 566–571. *https://doi.org/10.3928/00485713–20211109–01*

[5] Julien, J., Ayer, T., Tapper, E. B., Barbosa, C., Dowd, W. N., & Chhatwal, J. (2021, December 8). Effect of increased alcohol consumption during COVID–19 pandemic on alcohol-associated liver disease: A modeling study. Hepatology. *https://doi.org/10.1002/hep.32272*

[6] National Institute on Drug Abuse. (2021, December 20). COVID–19 & Substance Use. National Institutes of Health. *https://nida.nih.gov/drug-topics/comorbidity/covid–19-substance-use*

[7] Substance Abuse and Mental Health Services Administration. (2020). Key substance use and mental health indicators in the United States: Results from the 2019 National Survey on Drug Use and Health (HHS Publication No. PEP20–07–01–001, NSDUH Series H–55). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from *https://www.samhsa.gov/data/sites/default/files/reports/rpt29393/2019NSDUHFFRPDFWHTML/2019NSDUHFFR090120.htm*

[8] American Psychological Association (2021). Worsening mental health crisis pressures psychologist workforce. 2021 COVID–19 Practitioner Survey. Retrieved from: *https://www.apa.org/pubs/reports/practitioner/covid–19–2021.*

[9] National Center for Health Statistics. (2022). Provisional Monthly National and State-Level Drug Overdose Death Counts. Centers for Disease Control and Prevention. Retrieved from: *https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm.*

[10] Osgood, K., Sheldon-Dean, H., & Kimball, H. (2021). 2021 Children's Mental Health Report: The Impact of the COVID–19 Pandemic on Children's Mental Health. Child Mind Institute. Retrieved from: *http://wvspa.org/resources/CMHR–2021-FINAL.pdf*5555

[11] Center for Translational Neuroscience. (2021). RAPID-EC Fact Sheet: Still in Uncertain Times; Still Facing Hunger. University of Oregon. Retrieved from: *https://www.uorapidresponse.com/our-research/still-in-uncertain-times-still-facing-hunger; Center for Translational Neuroscience. (2021). RAPID-EC Fact Sheet: Emotional Distress On the Rise for Parents . Again. University of Oregon. Retrieved from: https://www.uorapidresponse.com/emotional-distress-on-rise-again'utm—medium=email&utm—source=email—link&utm—content=baby—monitor—11042021&utm—campaign=Q1—2022—Policy+Center—Resources*

[12] Ullmann, H., Weeks, J. D., Madans, J. H. (2021). Disparities in stressful life events among children aged 5–17 years. National Center for Health Statistics. *https://dx.doi.org/10.15620/cdc:109052*

[13] Treglia, D., Cutuli, J. J., Arasteh, K., J. Bridgeland, J.M., Edson, G., Phillips, S., & Balakrishna, A. (2021). Hidden Pain: Children Who Lost a Parent or Caregiver to COVID–19 and What the Nation Can Do to Help Them. COVID Collaborative.

cent, respectively.[14] In recent months, children's hospitals have reported their highest number of children "boarding" in hospital emergency departments awaiting treatment.[15] During the first three-quarters of 2021, children's hospitals reported a 14 percent increase in mental health related emergencies and a 42 percent increase in cases of self-injury and suicide, compared to the same time period in 2019.[16] Faced with such data, in December 2021, the U.S. Surgeon General issued an advisory calling for a unified national response to the mental health challenges young people are facing.[17] Considering the rarity of such advisories, this further underscores the need for action to help stem the long-term impacts of the pandemic on the mental health and well-being of children and adolescents.

Furthermore, the burdens of the pandemic have not been proportionately borne by race and ethnicity. People of color are at a higher risk of infection, hospitalization, and death from the virus as compared to their White counterparts.[18] The pandemic has also shone a light on the historic disparities in access to behavioral health care among populations of color, which has further harmed their mental well-being since the start of this crisis.[19] This includes children and adolescents. Rates of suicide, which have traditionally been high predominantly among White and Native American kids, have risen sharply among Black and African American youth.[20] Black and Hispanic children lost a parent or a caregiver at more than two times the rate of White children, while American Indian, Alaska Native, and Native Hawaiian and Pacific Islander children lost caregivers at nearly four times that rate.[21] Additionally, young people within other marginalized populations, including those who identify as LGBTQ+ and children with developmental and physical disabilities, have been disproportionately impacted.[22]

Even on their own, these data are striking, but taken in aggregate, they could not provide a clearer picture: action is urgently needed. The COVID–19 pandemic continues to be incredibly challenging on an individual and societal level, but it has provided us an opportunity to reevaluate how we deliver mental health services. APA applauds Congress for the COVID-relief funding that has been enacted since March 2020. Congress' swift action was critical to addressing the crisis we were facing and continue to face. However, investments in mental health care cannot just be reactive and made solely on an emergency basis. Consistent, steady, sustainable support is necessary to meet the challenges and growing demand that will continue to arise in the future. We must start the hard work of rebuilding our public health and preparedness and response system now. We cannot afford to wait until the next crisis occurs.

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[14] Leeb, R. T., Bitsko, R. H., Radhakrishnan, L., Martinez, P., Njai, R., Holland, K. M. (2020) Mental Health-Related Emergency Department Visits Among Children Aged <18 Years During the COVID–19 Pandemic—United States, January 1-October 17, 2020. Morbidity and Mortality Weekly Report, 69(45), 1675–1680. *http://dx—doi.org/10—15585/mmwr—mm6945a3*

[15] Children's Hospital Association. (n.d.). Emergency Room Boarding of Kids in Mental Health Crisis. Retrieved from: *https://www.childrenshospitals.org/—media/Files/CHA/Main/Issues—and—Advocacy/Key—Issues/Mental percent20Health/2021/Boarding—fact—sheet—121421.pdf*

[16] Children's Hospital Association. (2021). COVID–19 and Children's Mental Health. Retrieved from: *https://www.childrenshospitals.org/-/media/Files/CHA/Main/Issues—and—Advocacy/Key—Issues/Mental-Health/2021/covid—and—childrens—mental—health—factsheet—091721.pdf'la—en&hash—F201013848F9B9C97FAE16A89B01A38547C7C5C7*

[17] Office of the U.S. Surgeon General. (2021). Protecting Youth Mental Health: The U.S. Surgeon General's Advisory. Retrieved from: *https://www.hhs.gov/sites/default/files/surgeon—general—youth—mental—health—advisory.pdf*

[18] Centers for Disease Control and Prevention. (2021). Risk for COVID–19 Infection, Hospitalization, and Death By Race/Ethnicity. Retrieved from: *https://www.cdc.gov/coronavirus/2019—ncov/covid—data/investigations—discovery/hospitalization—death—-by—race—-ethnicity.html*

[19] McKnight-Eily, L. R., Okoro, C. A., Strine, T. W., et al. (2021). Racial and Ethnic Disparities in the Prevalence of Stress and Worry, Mental Health Conditions, and Increased Substance Use Among Adults During the COVID–19 Pandemic—United States, April and May 2020. Morbidity and Mortality Weekly Report, 70(5), 162–166. *http://dx—.doi—org/10-15585/mmwr—mm7005a3*

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[21] Treglia, D., Cutuli, J. J., Arasteh, K., J. Bridgeland, J.M., Edson, G., Phillips, S., & Balakrishna, A. (2021). Hidden Pain: Children Who Lost a Parent or Caregiver to COVID–19 and What the Nation Can Do to Help Them. COVID Collaborative.

[22] Morning Consult & the Trevor Project. (2021) Issues Impacting LGBTQ Youth Retrieved from:*https://www.thetrevorproject.org/wp—content/uploads/2021/12/TrevorProject—Public—Final–1.pdf*

Further, APA supports the recent introduction of the PREVENT Pandemics Act discussion draft, which addresses critical gaps in the way our public health infrastructure responds to pandemics and other public emergencies, particularly as it relates to the roles and responsibilities of the Substance Abuse & Mental Health Services Administration (SAMHSA). However, this is also not enough. APA is hopeful and optimistic that this Committee will also consider comprehensive legislation reflective of the fact that mental health is integral to overall health. As such, APA offers the following recommendations focused on (1) Strengthening the Mental Health Care Workforce; (2) Improving Access to Mental Health Care for Children and Youth; (3) Promoting Integration of Primary Care and Behavioral Health; (4) Continuation of Evidence-Based Mental Health Programs; (5) Ensuring Parity for Behavioral and Physical Health Care; and (6) Investing in Youth Mental Health Research.

Strengthening the Mental Health Care Workforce

A strong mental health workforce is critical to combating the long-term impact of the pandemic and remedying longstanding access gaps. Nationwide, even before COVID–19, the U.S. was facing a serious shortage of mental and behavioral health providers, including psychologists, with every state having documented mental health professionals shortage areas.[23] By 2030, these shortages are projected to worsen significantly,[24],[25] with rural communities facing major challenges in recruiting licensed mental and behavioral health care professionals.[26] Despite the need for these services, there are multiple barriers to educating and training psychologists, including the cost of attending graduate school, which most students are increasingly financing by taking on debt. Doctoral psychologists graduate with an average student debt load of between $95,000 and $160,000 from their graduate degrees alone, and close to half of doctoral-level psychologists rely on loans or their own funds to pay for graduate school, which takes on average 5–6 years to complete.[27] Data show that psychology graduate students have difficulties affording health care, are concerned about being able to afford completing their training requirements, and have difficulties focusing on their studies as a result of trying to make ends meet.[28] At the same time, student loan-related actions taken by the Federal Government over the last decade have disproportionately impacted graduate students. This includes the imposition of higher interest rates and multiple loan origination fees, as well as the elimination of subsidized Federal loans.[29] These factors further increase the cost of Federal borrowing, particularly when financing graduate education.

Furthermore, as a result of a variety of factors, including lack of generational wealth, students of color, first-generation, and lower socioeconomic status students tend to borrow significantly more, both for their undergraduate and postbaccalaureate degrees.[30] This is true across all fields, but data show that low-income students and students of color working toward doctoral psychology degrees also disproportionately rely on student loans.[31] The prospect of adding further debt

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[23] Bureau of Health Workforce (2019) Designated Health Professional Shortage Area Statistics Health Resources and Services Administration; U.S. Department of Health and Human Services Retrieved from *https://data.hrsa.gov/hdw/Tools/MapToolQuick—aspx—mapName—HPSAMH.*

[24] Health Resources and Services Administration. (n.d.). Behavioral Health Workforce Projections, 2016–2030: Clinical, Counseling, and School Psychologists. Retrieved from: *https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/psychologists–2018.pdf*

[25] Bureau of Labor Statistics. Occupational Outlook Handbook, Psychologists. U.S. Department of Labor. Retrieved from *https://www.bls.gov/ooh/life-physical-and-social-science/psychologists.htm*

[26] Rural Health Information Hub. (2021). Rural Mental Health. RHIhub. *https://www.ruralhealthinfo.org/topics/mental-health*

[27] Doran, J., Kraha, A., Marks, L., Ameen, E. & El-Ghoroury, N. (2016). Graduate Debt in Psychology: A Quantitative Analysis. Training and Education in Professional Psychology, 10(1), 3–13.

[28] Lantz, M. M. (2013). Uncovering the graduate student economic landscape: A difficult but necessary dialog. Society of Counseling Psychology Newsletter, 34, 22–23. Retrieved from *http://www.div17.org/wp—content/uploads/SCP17—2013–9.pdf*

[29] U.S. Department of Education (n.d.) Federal Interest Rates and Fees Federal Student Aid Retrieved from:*https://studentaid.gov/understand-aid/types/loans/interest-rates*

[30] Miller, B. (2019, December 2) The Continued Student Loan Crisis for Black Borrowers Center for American Progress Retrieved from: *https://www.americanprogress.org/issues/education-postsecondary/reports/2019/12/02/477929/continued-student-loan-crisis-black-borrowers/*

[31] Wilcox, M. M., Barbaro-Kukade, L., Pietrantonio, K. R., Franks, D. N., & Davis, B. L. (2021). It takes money to make money: Inequity in psychology graduate student borrowing and

often serves as a disincentive to pursuing advanced degrees. Higher student loan debt further impedes workforce diversity, including in mental and behavioral health care fields, where demand for representative, culturally competent providers is high.[32] Finally, research shows that debt also impacts career choice by, for example, reducing the probability that qualified professionals will enter public service careers.[33]

To incentivize qualified providers to pursue careers delivering care to underserved populations, APA encourages the passage of the bipartisan Mental Health Professionals Workforce Shortage Loan Repayment Act (S. 1578), which authorizes a new student loan repayment program for mental health care professionals who commit to working in an area lacking accessible care.

Additionally, to help decrease the reliance on student loans and eradicate some of the barriers obstructing the growth and diversification of this critical workforce, Congress must invest in programs that fund the education and training of future mental health care providers. Unlike physicians, doctoral-level psychologists are not eligible for Medicare-funded residency programs, which provides billions of dollars to support the expansion of the physician workforce through Graduate Medical Education or GME. In addition, although clinical psychology interns go through a training process similar to psychiatry residents, services provided by trainees under the supervision of a licensed psychologist are not reimbursable under Medicare; despite trainees having an average of 500–700 hours of direct patient experience It is policies like these that inhibit the expansion of the mental and behavioral health workforce. Before the COVID–19 pandemic, there was a projected shortage of over 13,000 psychologists by 2030.[34] With the rising mental and behavioral health needs associated with COVID–19, this shortage is expected to grow significantly. Increased funding to the programs below administered by the Health Resources and Services Administration (HRSA) and Substance Abuse and Mental Health Services Administration (SAMHSA) is essential to maintain a steady pipeline of trained psychologists to meet the anticipated mental health needs of the entire nation. APA calls for the expeditious reauthorization of the following programs, which are set to expire at the end of Fiscal Year (FY) 2022:

The Graduate Psychology Education Program (GPE) is the Nation's primary Federal program dedicated solely to the education and training of doctoral-level psychologists. GPE provides grants to accredited psychology doctoral, internship and postdoctoral training programs to support the interprofessional training of psychology graduate students while also providing mental and behavioral health services to underserved populations in rural and urban communities. APA urges the Committee to reauthorize this important program at $50 million per year, a robust increase commensurate with the scale of mental health and substance use disorder needs and the dangerous shortage in the workforce.

The Minority Fellowship Program (MFP) serves a dual purpose to both increase the number of minority mental health professionals and increase access to mental health services in underserved areas. It provides funding for the training, career development and mentoring of mental and behavioral health professionals to work with ethnic minorities. The program focuses on training students, postdoctoral fellows and residents to be culturally and linguistically competent to adequately address the needs of minorities in underserved areas. It funds trainees in psychology, nursing, social work, psychiatry, addiction counseling, professional counseling and marriage and family therapy.

Decades of psychological research has shown that minority youth report less use of mental health services than non-Hispanic white youth.[35] However, strong bar-

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financial stressors. Training and Education in Professional Psychology, 15(1), 2–17 *https://doi.org/10.1037/tep0000294*

[32] Sullivan, L., Meschede, T., Shapiro, T., & Escobar, F. (September 2019). Stalling Dreams: How Student Debt is Disrupting Life Chances and Widening the Racial Wealth Gap. Institute on Assets and Social Policy, Heller School for Social Policy and Management at Brandeis University Retrieved from:*https://heller—brandeis—edu/iere/pdfs/racial-wealth-equity/racial-wealth-gap/stallingdreams-how-student-debt-is-disrupting-lifechances.pdf*

[33] Choi, Y. (2014). Debt and college students' life transitions: The effect of educational debt on career choice in America. Journal of Student Financial Aid, 44(1), 3. Retrieved from *https://ir—library—louisville.edu/cgi/viewcontent—cgi—article—1050&context—jsfa*

[34] American Psychological Association. (2018). A Summary of Psychologist Workforce Projections: Addressing Supply and Demand from 2015–2030 Retrieved from *https://www.apa.org/workforce/publications/supply demand/summary.pdf*

[35] Marrast, L., Himmelstein, D. U., & Woolhandler, S. (2016). Racial and ethnic disparities in mental health care for children and young adults: A national study. International Journal of Health Services, 46(4), 810–824.

riers for ethnic minorities to access mental health services continue to persist. These include a lack of bilingual providers and lack of culturally competent care. Therefore, the MFP is essential to ensure there are culturally competent behavioral health professionals, as they are a key component to improving health care outcomes for underserved communities. With the shortage of qualified minority psychologists to address the needs of minority populations, the importance of MFP is all the more important.

The Behavioral Health Workforce Education and Training (BHWET) Program supports pre-degree clinical internships and field placements for a broad array of behavioral health professionals, including doctoral-level psychology students, master's-level social workers, school social workers, professional and school counselors, psychiatric mental health nurse practitioners, marriage and family therapists, and occupational therapists. The program is also a key source of support for other mental health training programs and substance use disorder prevention efforts. Preserving this program is key to reaching underserved populations, as well as meeting the needs of patients wherever they are on the spectrum of mental health needs, from mobile crisis services for those with need for immediate intervention to early screening and prevention services for those who may be experiencing minor symptoms of a behavioral health disorder.

The Integrated Substance Use Disorder Training Program (ISTP) expands the number of nurse practitioners, physician assistants, health service psychologists, and/or social workers trained to provide mental health and substance use disorder (SUD), including opioid use disorder (OUD) services in underserved community-based settings that integrate primary care, mental health, and SUD services.

Improving Access to Mental Health Care for Children and Youth

Significant unmet child and adolescent behavioral health needs existed nationwide, even prior to COVID–19.[36],[37] Suicide rates among children aged 10 and older have also climbed significantly each year since 2007, making it the second most common cause of death among adolescents before the pandemic.[38] The stakes of untreated mental and behavioral health symptoms for children and adolescents are exceptionally high. Failing to detect and address early indicators of a mental or behavioral health disorder can have profound consequences on the overall trajectory of a child's life, including a greater likelihood of difficulties with learning, addiction to substances, lower employment prospects, and involvement with the criminal justice system of difficulties with learning, addiction to substances, lower employment prospects, and involvement with the criminal justice system.[39] Sacks, V., & Murphey, D. (2018). The prevalence of adverse childhood experiences, nationally, by state, and by race/ethnicity. Child Trends. Retrieved from: *https://www.childtrends.org/publications/prevalence-adverse-childhood-experiences-nationally state-race-ethnicity;*

Even before COVID–19, many young people were already prolific users of social media. Throughout the pandemic, however, for many this became the only means of retaining a sense of connection to their peers and communities. Yet psychological science suggests a darker side to young people's engagement with social media, with results suggesting risks that far exceed the findings revealed in recent months from social media employees themselves. Note that the brain undergoes significant changes at pubertal outset, and emerging research suggests that digital media change neural activation and brain development in long-term and potentially permanent ways. In addition, research demonstrates that youth are highly susceptible to peer influence on social media, they are exposed to more frequent and more severe discrimination online, many teens consume content that actually promotes maladaptive and dangerous behaviors (e.g., cutting, fasting, purging), and like

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[36] Centers for Disease Control and Prevention (2020) Youth Risk Behavior Surveillance Retrieved from:*https://www.cdc.gov/mmwr/volumes/69/su/pdfs/su6901-H.pdf*

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[38] Centers for Disease Control and Prevention. (2020). State Suicide Rates Among Adolescents and Young Adults Aged 10–24: United States, 2000–2018. National Vital Statistics Reports. Retrieved from:*https://www.cdc.gov/nchs/data/nvsr/nvsr69/NVSR–69–11–508.pdf*

[39] Sacks, V., & Murphey, D. (2018) The prevalence of adverse childhood experiences, nationally, by state, and by race/ethnicity. Child Trends. Retrieved from: *https://www.childtrends.org/publications/prevalence-adverse-childhood-experiences-nationally state-race-ethnicity;*

adults, they are prey to mis/disinformation campaigns on social media platforms.[40],[41]

To support a multi-tiered, population health approach, which includes continued clinical care through a more traditional "acute care" model for those experiencing behavioral health disorders, as well as mitigation strategies, such as early detection and intervention, for those at-risk of behavioral health conditions,[42] APA strongly urges the reauthorization of several pediatric mental health programs:

Programs for Children with a Serious Emotional Disturbance provide funds to government entities to deliver comprehensive community-based mental health services to children, youth, and young adults who have a serious emotional disturbance. These programs serve vulnerable, high-risk populations, and have shown to significantly improve the mental, social, and emotional functioning of children and adolescents with severe emotional disturbances through effective evidence-based services and have shown to significantly improve the mental, social, and emotional functioning of children and adolescents with severe emotional disturbances through effective evidence-based services and have shown to significantly improve the mental, social, and emotional functioning of children and adolescents with severe emotional disturbances through effective evidence-based services.[43]

Pediatric Mental Health Care Access Grants promote behavioral health integration into pediatric primary care by supporting pediatric mental health care telehealth access programs. Data show that psychological factors substantially influence physical health outcomes and efforts to address physical health needs are less likely to be effective without similar attention to behavioral health conditions.[44],[45] As such, to maximize the likelihood of a successful intervention, integrating children's physical and behavioral health care is critical. Reauthorizing the Pediatric Mental Health Care Access Grants program would further support the coordination between physicians and behavioral health providers.

Additionally, the Committee should consider the Pursuing Equity in Mental Health Act (S. 1795), which authorizes funding to support research on Black youth suicide, improve the pipeline of culturally competent providers, build outreach programs that reduce stigma, and develop a training program for providers to effectively manage disparities.

Schools also play a critical role in providing health care to many children, particularly as they can be key to both early detection and intervention efforts. In fact, in many communities, they are an essential—and often the only—source of meeting the physical and mental health needs of students and families. While some school districts leverage Medicaid funds to stretch scarce resources and create school-based mental health programs, shortages of school-based behavioral health professionals continue to persist.[46]

Improving the behavioral health and emotional well-being of all students, including by instituting evidence-based comprehensive behavioral health systems in schools, can help mitigate the impacts of pandemic-related learning loss,pandemic-related learning loss,pandemic-related learning loss,pandemic-related learning

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[40] Sherman, L. E., Payton, A. A., Hernandez, L. M., Greenfield, P. M., & Dapretto, M. (2016). The power of the "like" in adolescence. Psychological Science, 27(7), 1027–1035. *http://doi.org/10.1177/0956797616645673*

[41] S Nesi, J., Telzer, E. H., Prinstein, M. J. (in production). Handbook of Adolescent Digital Media Use and Mental Health. Accepted for Publication, Cambridge University Press.

[42] Evans, A. C., & Bufka, L. F. (2020). The Critical Need for a Population Health Approach: Addressing the Nation's Behavioral Health During the COVID–19 Pandemic and Beyond. Preventing Chronic Disease, 17. *http://dx.doi.org/10.5888/pcd17.200261*

[43] Substance Abuse and Mental Health Services Administration. (2017). The Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances Program: 2017 Report to Congress. Retrieved from: *https://store.samhsa.gov/sites/default/files/d7/priv/cmhi–2017rtc.pdf*

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[47] Dorn, E., Hancock, B., Sarakatsannis, J., & Viruleg, E. (2020, December 8). COVID–19 and learning loss-disparities grow and students need help. McKinsey & Company. *https://www.mckinsey.com/industries/public-and-social-sector/our-insights/covid–19-and-learning-loss-*

loss,pandemic-related learning loss,[47] and reduce the frequency and severity of mental health and substance use disorders.[48] Such a holistic approach provides a full complement of supports and services that establish multi-tier interventions and promotes positive school environments. They are built on collaborations between students, parents, families, community health partners, school districts, and school professionals, such as administrators, educators, and specialized instructional support personnel, including school psychologists.

Instead of employing resources only when a child experiences a crisis, our behavioral health system must focus resources earlier in life and address the factors that lead to such experiences. Oftentimes, this can be achieved in school-based settings, with the partnership and engagement of parents and families. Schools must receive more support to address these needs by increasing and retaining a highly trained workforce of diverse, culturally competent school-based mental health professionals. APA urges the Committee to pass the following legislation that would increase access to school-based mental health services:

The Mental Health Services for Students Act (S. 1841), which would build partnerships between local educational agencies, tribal schools, and community-based organizations to provide school-based mental health care for students and training for the entire school community to help identify early warning signs of a crisis and prevent its escalation.

The Comprehensive Mental Health in Schools Pilot Program Act (S. 2730), which would provide resources for low-income schools to develop a holistic approach to student well-being by building, implementing, and evaluating comprehensive school-based mental health programs. Integrating evidence-based, culturally competent social and emotional learning programs and trauma-informed approaches to teaching and student well-being help foster positive school climates and develop skills such as motivation and engagement, problem-solving, emotional intelligence, resilience, agency, and relationship building.[49]

Such universal programs also help address student behavioral challenges by implementing positive, non-punitive, restorative measures rather than retributive and exclusionary practices.[50]

The Increasing Access to Mental Health in Schools Act (S. 1811) would expand mental health services in low-income schools by increasing the number of school-based mental health professionals, including psychologists. This bill would provide schools with the ability to build long-term capacity to equitably address the mental and behavioral well-being of their students, which can have significantly positive impacts on their academic development and future success.

To further understand the implications of COVID–19 on the education of students, in terms of both their academic achievement and social and emotional development, Congress should invest in increased research and data collection through the Institute of Education Sciences (IES). IES supports research, reports data, and produces evidence-based resources to help improve educational outcomes for all students. Currently, IES is able to fund only one in ten grant applications it receives. Additionally, stronger collaboration and partnerships should be encouraged between the Department of Education, the Department of Health and Human Services, and the Substance Abuse and Mental Health Services Administration with respect to data collection efforts.

Finally, young people of college age face unique challenges when it comes to their mental health. A recent survey of college students finds that a large majority are experiencing emotional distress or anxiety due to the pandemic.[51] Future economic insecurity resulting from the pandemic is among the top concerns of college stu-

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[47] Dorn, E., Hancock, B., Sarakatsannis, J., & Viruleg, E. (2020, December 8). COVID–19 and learning loss-disparities grow and students need help. McKinsey & Company. *https://www.mckinsey.com/industries/public-and-social-sector/our-insights/covid–19-and-learning-loss-disparities-grow-and-students-need-help*

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[51] TimelyMD (2022). College Students More Concerned About COVID–19 Than Ever, New Survey by TimelyMD Finds. Retrieved from: *https://timely.md/college-students-more-concerned-about-covid–19-than-ever*

dents,[52] further contributing to stress, anxiety, and depression.[53],[54] Campus counseling centers, which even prior to COVID-19 were the only access point to mental health care for many college students, are seeing significant increases in demand for services, without a corresponding increase in resources, whether through funding, training, or staff. [55] This care is, in part, provided by psychology interns and trainees completing their education, under the supervision of counseling center staff. One of the impacts of the pandemic on college campuses, particularly earlier in the crisis was either the limiting or outright canceling of these internships, which hamstrung the ability of counseling centers to stay operational and continue training future practitioners. APA supports the Higher Education Mental Health Act (S. 3048) that would establish a national commission to study mental health concerns at institutions of higher education, and the reauthorization of the campus suicide prevention programs under the Garrett Lee Smith Memorial Act.

Promoting Integration of Primary Care and Behavioral Health

Psychologists have long been at the forefront of developing evidence-based integrated primary care and behavioral health services. One of the leading models of integrated care is the Primary Care Behavioral Health Model (PCBH), in which primary care providers, behavioral health consultants (BHCs), and care managers work as a team, sharing the same health record systems, administrative support staff, and waiting areas, and collaborate in monitoring and managing patient progress in order to improve the management of behavioral health problems and conditions. In the PCBH model the behavioral health consultant role is often, but not always, filled by a clinical psychologist.

The PCBH model is a truly population-based approach to integrated care, in which the goal is to improve both mental and physical health outcomes for the clinic's patients—of every age and condition—by managing behavioral health problems and bio-psychosocially influenced health conditions.[56] Generally, the BHC strives to see patients on the same day the primary care provider (PCP) requests help, ideally through a "warm hand-off," and works with the PCP to implement clinical pathways for treatment. An integrated care psychologist's day may include meeting with a parent of a child exhibiting behavioral difficulties or hyperactivity, seeing a new mother experiencing symptoms of depression, helping another patient manage chronic pain or diabetes, and working with another patient who has recently discontinued using his psychotropic medication. Both patients and providers have reported high levels of satisfaction with PCBH model services.[57],[58] From the patient's perspective, behavioral health services are seamlessly interwoven with medical care, mitigating the stigma often associated with behavioral health services.

The PCBH model is particularly well-suited to use in pediatric care. Interventions and supports to promote children's physical, behavioral, and emotional health can positively influence the long-term trajectory of their health and well-being into adulthood. Almost all children are seen in primary care, and it is estimated that one in four pediatric primary care office visits involve behavioral or mental health problems. Psychologists can be especially helpful in pediatric care because assessing behavioral and emotional issues in children is generally more difficult than in adults, and pediatric education traditionally focuses on children's physical health. In addition to improving treatment in this area, early childhood behavioral health

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[52] Chegg.org. (2021). Global Student Survey. Retrieved from: *https://www.chegg.com/about/wp-content/uploads/2021/02/Chegg.org-global-student-survey–2021.pdf.*

[53] Walsemann, K. M., Gee, G.C., & Gentile, D. (2015). Sick of Our Loans: Student Borrowing and Mental Health of Young Adults in the United States. Social Science and Medicine. 124, 85–93.

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[57] Petts, R. A., Lewis, R. K., Brooks, K., McGill, S., Lovelady, T., Galvez, M., & Davis, E. (2021). Examining patient and provider experiences with integrated care at a community health clinic. The Journal of Behavioral Health Services & Research, 1–18.

[58] Angantyr, K., Rimner, A., Norden, T., & Norlander, T. (2015). Primary care behavioral health model: Perspectives of outcome, client satisfaction, and gender. Social Behavior and Personality: An International Journal, 43(2), 287–301

services can help mitigate the effect of adverse social determinants of health. Ideally, integrated pediatric primary care includes a whole-family approach to services that encompasses screening and services for perinatal and maternal depression, domestic violence, and adverse childhood experiences.

Investing in evidence-based integrated primary and behavioral health care across multiple models would help us meet the current crisis, as more than a decade of research has shown that programs implementing the PCBH model, the collaborative care model (CoCM), and blended models of integrated care can increase access to care and achieve the health care triple aim of improving patient outcomes, increasing satisfaction with care, and reducing overall treatment costs. A comprehensive approach to supporting integrated care was just endorsed by the Primary Care Collaborative (PCC), a multi-stakeholder coalition of more than 60 clinician, patient, employer, and health care organizations committed to establishing an equitable, high value health care system based on effective primary care. PCC shared recommendations on integrating primary care and behavioral health in a letter to HHS Secretary Xavier Becerra and CMS Administrator Chiquita Brooks-LaSure, stating:

"At present, evidence supports multiple integrated behavioral health delivery models in primary care, including the collaborative care model and the primary care behavioral health model. To maximize the number of patients that can benefit from integrated care across diverse practice settings and communities, primary care payment options must be available to support a variety of evidence-based models of integration. Payment policy that supports multiple care integration models has two additional merits. It can support the development of real-world implementation evidence across diverse populations and spur further innovation in behavioral health integration at the practice level and in practice/payer collaboration. For these reasons, PCC supports a multi-component policy approach to behavioral health integration." [59]

A concerted effort to promote evidence-based integrated primary and behavioral health is needed because unfortunately, implementation of integrated care remains limited. CMS data show that use of the Medicare behavioral health integration billing codes established by CMS in 2017 roughly doubled between 2018 and 2019, with less than a quarter of providers billing using a psychiatrist-based collaborative care model and more than 70 percent of providers using a PCBH or similar model of care. However, it appears that well under 1 percent of Medicare beneficiaries receive care through integrated care model programs between 2018 and 2019, with less than a quarter of providers billing using a psychiatrist-based collaborative care model and more than 70 percent of providers using a PCBH or similar model of care. However, it appears that well under 1 percent of Medicare beneficiaries receive care through integrated care model programs. [60] Adoption of PCBH and other integrated care models is often challenging for primary care providers, as they face barriers related to physical office space, the need for improved information technology systems, management procedures, clinical staffing and policies, health records and data tracking practices, and provider education and training.

APA supports the provision of Federal financial and technical assistance to aid in the expansion of integrated care, whether provided through partnerships (including state agencies) or through direct aid to primary care providers. Initiatives and incentives to promote integrated care should support implementation of not just PCBH programs, but all evidence-based models of integrated care. Because of differences in providers' patient populations and access to behavioral health providers, there is no "one-size-fits-all" approach to effective integrated primary care. APA urges Congress to continue to give primary care practices the flexibility to choose the model of integrated care that works best for their community and that which will most strongly expand access to integrated primary and behavioral health care, and improve population health.

Continuation of Evidence-Based Mental Health Programs

APA appreciates continued Federal support for the Community Mental Health Services Block Grant, which provides a bedrock of support for community-based mental health screening, evaluation, and treatment programs across all states and

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[59] Primary Care Collaborative. (January 26, 2022). The PCC sends Behavioral Health Integration Recommendation Letter to HHS/CMS (p. 3). Retrieved from: *https://www.pcpcc.org/2022/01/26/pcc-sends-behavioral-health-integration-recommendation-letter-hhscms*

[60] Centers for Medicare and Medicaid Services. (2021). Medicare Physician & Other Providers—By Provider and Service Dataset. Retrieved from: *https://data.cms.gov/provider-summary-by-type-of-service/Medicare-physician-other-practitioners/Medicare-physician-other-practitioners-by-provider-and-service*

communities. The effectiveness of any mental health system depends on its recognition of mental health as existing on a spectrum, and its ability to meet the needs of patients wherever they are on that spectrum and wherever they are in the community. Without access to crisis services, patients often find themselves languishing in emergency rooms or seeking treatment in other inappropriate settings. We strongly support the CAHOOTS Act (S. 764), which incentivizes state Medicaid programs to cover services provided by round-the-clock mobile crisis teams, and Rep. Bustos' Crisis Care Enhancement Act (H.R. 4305), which reserves a higher set-aside amount under the block grant for crisis services. The increased funding for these services provided under these bills will, in addition to improving patient outcomes, increase the efficiency of states' mental health care systems and help enable national initiatives around mental health—such as the 988 National Suicide Prevention Lifeline—to reach their full potential.

Ensuring Parity for Behavioral and Physical Health Care

Enactment of the Mental Health Parity and Addiction Equity Act (MHPAEA) in 2008 promised to end insurance discrimination against individuals with mental health and substance use disorders. Unfortunately, frequent noncompliance with the law and inadequate enforcement has kept us from achieving this promise.

Just last week the U.S. Departments of Labor, Health and Human Services, and Treasury issued their latest joint report to Congress on enforcement of MHPAEA, as required under the law. Importantly, the 2022 MHPAEA enforcement report is the first since Congress established a new enforcement tool under the Consolidated Appropriations Act of 2021 (CAA): the requirement that health plans and issuers perform comparative analyses of their non-quantitative treatment limitations (NQTLs) to demonstrate their compliance with MHPAEA and provide those analyses to the agencies upon request for purposes of determining compliance. Health plans, administrators, and issuers are continuing to apply discriminatory NQTLs (such as preauthorization requirements, admission criteria for provider networks, and reimbursement rates) to mental health and substance use disorder benefits and providers in order to constrain their beneficiaries' use of services.

Most of the responsibility for enforcement has fallen to the Employee Benefits Security Administration (EBSA) within the Department of Labor (DOL), which has jurisdiction over MHPAEA compliance for approximately 2 million health plans covering more than 136 million Americans. Out of this universe, EBSA has issued 156 letters to plans and issuers requesting comparative analyses for their NQTLs. As the report describes, none of the comparative analyses EBSA reviewed contained sufficient information upon initial receipt. EBSA subsequently obtained sufficient information for a review of NQTLs in 30 plans, and in all cases made an initial determination of non-compliance with MHPAEA.

We applaud the agencies' focus on NQTLs and its new enforcement authority, and for prioritizing review of both in-network and out-of-network reimbursement rates for mental health and substance use providers. A 2019 Milliman Research Report compared health plans' in-network reimbursement rates for behavioral health office visits as a percentage of Medicare-allowed amounts with reimbursement rates for medical/surgical office visits, and found that primary care reimbursement rates were nearly 24 percent higher than behavioral health visit rates. Not surprisingly, the same study found that consumers were almost five and a half times as likely to go out-of-network for behavioral health services as for medical/surgical primary care. APA frequently hears from psychologists who have chosen to stop participating in insurance plans because of low reimbursement rates and onerous administrative hassles, and this level of frustration is being exacerbated by the heavy demand for services during the pandemic.

The 2022 MHPAEA Report describes DOL's valiant effort to enforce the law, which we commend, but it is clear stronger tools are needed. We strongly support the agency's request for the authority to assess civil monetary penalties for parity violations—for group health plan, issuers, and administrators—as would be established under legislative language included in the House-passed Build Back Better Act. Congress should enact legislation this year to provide this authority.

In addition, we support the Parity Implementation Assistance Act (S. 1962) to assist states in using the new enforcement authority granted under the Consolidated Appropriations Act to obtain comparative analyses and information from insurers on their implementation of MHPAEA. States have the authority, but often not the resources, to play a role in enforcing MHPAEA.

Finally, we urge the Committee to approve legislation to close the loophole that allows self-funded non-Federal Government-sponsored health plans to opt out of

complying with MHPAEA. Sadly, even after all we've experienced with the mental health effects of the pandemic and the acceleration of drug overdose deaths over the past 2 years, these plans covering our public servants are far more likely to claim an exemption from mental health parity requirements than for any other type of coverage requirement. It has been 14 years since Congress passed MHPAEA to end discrimination by diagnosis against those in need of mental health and substance use treatment, and now is certainly the time to do the same for government employees. Congress should also eliminate the ability of self-funded non-Federal Government health plans to opt out of other beneficiary protections, such as benefits described under the Newborns' and Mothers' Health Protection Act of 1996 and the Women's Health and Cancer Rights Act of 1998.

No Surprises Act

APA urges the Committee to investigate the disproportionate impact of the Interim Final Rules issued last year under the No Surprises Act on mental and behavioral health providers. APA and ten of the top mental and behavioral health organizations sent a letter to U.S. Department of Health and Human Services Secretary Xavier Becerra on January 25, 2022, requesting a stay on enforcement of requirements affecting routine mental and behavioral health service.[61] Collectively, we expressed concerns with the impact the IFRs will have on access to mental and behavioral services in communities that have long lacked access to these services. Our practitioners have a long-standing practice of being transparent about fees with their patients as is required under professional ethics codes. We have broad concerns that when CMS develops the rules for Good Faith Estimates (GFEs) for insured patients, insurers will use the information contained in the required Good Faith Estimates (GFEs) as a mechanism or justification to limit treatment beyond the scope of the GFEs. We also urge that those rules do not carry over the flawed Part I dispute resolution provisions identified in the American Medical Association (AMA) and American Hospital Association (AHA) lawsuit. We, and other mental and behavioral organizations, welcome the opportunity to work with the Committee to ensure unnecessary administrative burdens do not take away from the ability of mental and behavioral health providers to provide their patients access to quality treatment. Investing in Youth Mental Health Research

This is surely the year for Congress to address the growing crisis this Committee has identified by adding significant funds to NIH for an initiative to strengthen youth mental health. APA is calling for a billion-dollar investment in this initiative: this research would pay dividends for decades. Mental health issues, particularly for young people, affect their entire trajectory of life,[62] bringing struggles with education, employment, and close relationships. Mental disorders drain our economy through lost productivity and preventable utilization of the healthcare system and add costs within the juvenile justice system, to say nothing of the enormous suffering, the loss, and the personal toll exacted by mental disorders. Through research funded by NIMH, NICHD and NIMHD, we have learned a great deal about how to identify those at risk and engage them in preventive programs. But there is much more to learn and to apply in order to develop interventions, target them appropriately, and treat young people when prevention fails. We need research on primary prevention programs that are ready to be brought to scale, universal socioemotional skills learning, safe social media interaction, and community-based approaches to support kids' healthy development.

Every year, approximately 1.5 million Americans attempt to end their own lives due to suffering from mental health symptoms. Millions more have significant impairments in their functioning at work and in their relationships as parents and romantic partners. This is largely preventable based on psychological science that could be used to integrate mental health screening, preventions, resilience practices, and evidence-based interventions that we know can significantly reduce mental health symptoms today, and ensure that children are developing with far fewer risks of mental health difficulties in the decades to ensure that children are developing with far fewer risks of mental health difficulties in the decades to ensure that

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[61] American Psychological Association letter to U.S. Department of Health and Human Services Secretary Xavier Becerra. (January 25, 2022). Retrieved from: *https://votervoice.s3.amazonaws.com/groups/apaadvocacy/attachments/Sign-on percent20letter percent20No percent20Surprises percent20Act.pdf*

[62] Veldman, K., Reinjeveld, S. A., Ortiz, J. A., Verhulst, F. C., & Bultman, U. (2015). Mental health trajectories from childhood to young adulthood affect the educational and employment status of young adults: results from the TRAILS study. J. Epidemiological Community Health, 69(6). 588–593

children are developing with far fewer risks of mental health difficulties in the decades to come. [63]

APA is heartened by the focus on mental health in Congress, and eager to work with this Committee and its Members to develop legislation and enact the bills cited above. Your actions now can make all the difference in how many people are treated for their mental health problems and strengthened and fortified against developing problems. Together we can resolve the problems created by an inadequate mental health workforce and improve the capacity of the health care system to serve people who need immediate treatment. Our investment in mental health research now will guide improved prevention and treatment for decades to come. APA is a ready partner and looks forward to working with the Committee to put in place critical changes to our current system of care that will save lives and ensure access to care.

[SUMMARY STATEMENT OF MITCH PRINSTEIN]

During the COVID–19 pandemic, adults' mental and behavioral health needs increased exponentially compared to 2019, and remain unmet for many. For example, over 47 percent of adults with serious mental illness report having unmet needs. Youth mental health is also at an alarming point, with disproportionate impact on youth from communities of color and marginalized communities. Children's hospitals have documented a 42 percent increase in cases of self-injury and suicide, compared to 2019. APA urges Congress to consider the six following issue areas to strengthen existing programs and/ or consider legislation to address these devastating developments.

Strengthening the Mental and Behavioral Workforce:

- Pass the Mental Health Professionals Workforce Shortage Loan Repayment Act (S. 1578).
- Reauthorize programs administered by HRSA and SAMHSA, including GPE, MFP, BHWET, ISTP.

Improving Access to Mental Health Care for Children and Youth:

Reauthorize:

- Pediatric mental health programs that support children with serious emotional disturbance.
- The Pediatric Mental Health Care Access Grants program.
- Campus suicide prevention programs under the Garrett Lee Smith Memorial Act.

Consider:

- The Pursuing Equity in Mental Health Act (S. 1795).
- The Higher Education Mental Health Act (S. 3048).

Pass:

- The Mental Health Services for Students Act (S. 1841).
- The Comprehensive Mental Health in Schools Pilot Program Act (S. 2730).
- The Increasing Access to Mental Health in Schools Act (S. 1811).

Promoting Integration of Primary Care and Behavioral Health:

- Provide Federal financial and technical assistance to aid in the expansion of integrated primary and behavioral care services provided through use of evidence-based models including the Primary Care Behavioral Health (PCBH) model and Collaborative Care (CoCM) model.

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[63] Fortgang, R. G., & Nock, M. K. (2021). Ringing the Alarm on Suicide Prevention: A Call to Action. Psychiatry, 84(2), 192–195. *https://doi.org/10.1080/00332747.2021.1907871*

Continuation of Evidence-Based Mental Health Programs:

- Continue support for the Community Mental Health Services Block Grant.
- Consider the CAHOOTS Act (S. 764)
- Consider the Crisis Care Enhancement Act (H.R. 4305).

Ensuring Parity for Behavioral and Physical Health Care:

- Enact legislative language included in the House-passed Build Back Better Act to strengthen DOL's enforcement of the Mental Health Parity and Addiction Equity Act (MHPAEA).
- Enact legislation to close the loophole that allows self-funded non-Federal Government-sponsored health plans to opt out of complying with MHPAEA.
- Enact the Parity Implementation Assistance Act (S. 1962)

No Surprises Act:

- Investigate the disproportionate impact of the Interim Final Rules issued last year under the No Surprises Act on mental and behavioral health providers.

Investing in Mental Health Research:

- Support a billion-dollar investment in IMH, NICHD and NIMHD funding.

The CHAIR. Thank you.

Dr, Durham.

STATEMENT OF MICHELLE P. DURHAM, M.D., MPH, FAPA, DFAACAP, VICE CHAIR OF EDUCATION, DEPARTMENT OF PSYCHIATRY, CLINICAL ASSOCIATE PROFESSOR OF PSYCHIATRY & PEDIATRICS, BOSTON MEDICAL CENTER, BOSTON UNIVERSITY SCHOOL OF MEDICINE, BOSTON, MASSACHUSETTS

Dr. DURHAM. Thank you, Chair Mary, Ranking Member Burr, and Senator Murkowski, and distinguished Members of the Senate HELP Committee for holding this hearing and providing me with the opportunity to speak with you today. My name is Dr. Michelle Durham. I am a Pediatric and Adult Psychiatrist at Boston Medical Center and Board Certified in Addiction Medicine. In my over 10 years at BMC and Academic Medical Center in New England's largest safety net hospital, I have never seen our mental health care services stretched so far beyond their capacity as they are now.

Since late December 2021, we have had 30 plus patients in our psychiatric emergency Department, more than four times its capacity, presenting with a much higher level of acuity, some waiting for evaluation, and others boarding a waiting for placement inpatient psychiatric unit. The patients we serve at BMC are predominantly low income, with approximately half of our patients covered by Medicaid or the Children's Health Insurance Program, the highest percentage of any acute care hospital in Massachusetts.

70 percent of our patients identify as Black or Latino, approximately one in three speak a language other than English as their

primary language, and over have live at or below the Federal poverty level. BMC has a particular expertise and connecting marginalized communities to health and social services, and yet we still find it happens all too often that our patients with co-occurring mental health and substance use disorders get stuck in a revolving door, falling in and out of mental health and substance use treatment systems, in many cases ending up on the streets either episodically or chronically homeless, only to present repeatedly to our emergency Department.

One of the issues at play is that the necessary supports for these patients are not in place, including affordable low barrier housing and coordinated care integrated with a supportive community. The question is really how do we get people with co-occurring mental health and substance use everything they need to survive and be healthy?

BMC is in the very early stages of implementing a housing first approach in partnership with the city of Boston to get people living on the streets, just steps from our hospital campus, oftentimes living with co-occurring mental health and substance use issues housed first, and then provide wraparound medical services and social supports. Our hope is that this can work to break the vicious cycle for these folks, many of which are BMC patients and eventually can serve as a model for other municipalities replicate.

Our system is also in the process of constructing an 82 bed psychiatric facility in nearby Brockton, Massachusetts, to address the shortage of inpatient psychiatric beds and increase our ability to treat the mental health and substance use needs of our patients from across the region. The facility is expected to provide 56 inpatient psychiatric beds with the capacity to treat patients with co-occurring disorders and 20 26 clinical stabilization service beds.

We estimate that the project will involve a total of $27 million in sunken startup cost, a barrier that the Federal Government could help lower to incentivize capital investments to expand inpatient psychiatric capacity. As a Black, Spanish-speaking psychiatrist waiver to prescribe buprenorphine for opioid use disorder, I am all too aware of the patients our treatment systems are failing to reach.

Preliminary reports from the CDC indicate that the U.S. has eclipsed 100,000 annual drug overdose deaths for the first time ever. While nationally, overdose death rates have increased in every major demographic group in recent years, black men have experienced the largest increases. Even in Massachusetts, where we have seen population wide drug overdose death rates leveled off in recent years, the death rates for black men stand out in stark contrast, having increased astounding 75 percent between 2019 and 2020. Communities of color are suffering disproportionately from COVID–19, and they are dying at disproportionate rates from substance use disorders, bearing the brunt of two compounding public health crises.

At the same time, black men have comparably low rates of mental health and substance use treatment. At BMC, we have launched the Health Equity Accelerator to eliminate the race based health equity gap by utilizing data driven and community based re-

search to inform and change the way we approach care for black people and people of color. While we don't yet have all the answers we seek, we do know that a one size fits all approach doesn't work and that access is strained across the mental health and substance use continuum.

That is why reauthorizing funding to support States and localities responding to mental health and the substance use crisis and flexible ways is crucial. Thank you to the Senate HELP Committee for your commitment to coming together on a bipartisan basis to sustain funding in these critical programs over time. I would like to end by providing a glimpse into the reality of what our patients face every day. In one of my recent shifts in our psychiatric emergency room, a man in his late 20's came in seeking help for his mental health and substance use.

In our short time together, he described his onset of opiate use at 9 years of age. His parents were both using substances. There was minimal supervision in the home. As we see, often the patient had experienced years of substance use, time in the correctional system, death of many family members, and unsuccessful relationships with limited supports.

He has been in and out of treatment over the years as well, but our system as currently designed ultimately exacerbates issues and prevents recovery. In order to make progress, we must work to transform our mental health and substance use care system into one that recognizes relapse as a reality, coordinates care, destigmatizing and decriminalize substance use, and ultimately one that sees the humanity and people with mental health and substance use issues as—that enable—that can enable them to recover and live healthy, fulfilling lives. Thank you for your time and I look forward to the discussion.

[The prepared statement of Dr. Durham follows:]

PREPARED STATEMENT OF MICHELLE P. DURHAM

Thank you Chair Murray, Ranking Member Burr, and distinguished Members of the Senate Committee on Health, Education, Labor, and Pensions (HELP) for holding this hearing and providing me with the opportunity to speak today about mental health and substance use disorders, and the role the Federal Government can play in responding to a growing crisis impacting millions of Americans across all ages.

My name is Dr. Michelle Durham, I am a pediatric and adult psychiatrist at Boston Medical Center (BMC), board certified in adult psychiatry, child psychiatry, and addiction medicine. I am Vice Chair of Education in the Department of Psychiatry at BMC, where I also trained for my residency. I hold a joint appointment at the Boston University School of Medicine as a Clinical Associate Professor of Psychiatry and Pediatrics.

Boston Medical Center is an academic medical center and the largest safety-net hospital in New England. The patients we serve at BMC are predominantly low-income, with approximately half of our patients covered by Medicaid or the Children's Health Insurance Program (CHIP) the highest percentage of any acute care hospital in Massachusetts. 70 percent of our patients identify as Black or Latinx, approximately one in three (32 percent) speak a language other than English as their primary language, and over half live at or below the Federal poverty level. The patients we see at BMC frequently have co-occurring mental health (MH) and substance use disorders (SUD) and oftentimes face numerous health-related social needs linked to poverty, including homelessness and malnutrition. The COVID–19 pandemic, structural racism, and economic crisis has further exacerbated the mental illness, substance use, and trauma experienced by our patients.

In my over 10 years at BMC, I have never seen our mental health care services stretched so far beyond their capacity as they are now. (It's even worse than when

I testified on this subject before the Senate Finance Committee in June 2021.) Since late December, we have had 30-plus patients in our psychiatric emergency department more than three to four times its capacity—presenting with a much higher level of acuity, some waiting for evaluation and others boarding awaiting placement in an inpatient psychiatric unit.

- In addition to emergency services, BMC provides a continuum of outpatient and inpatient mental health and addiction services, including:
- The Grayken Center for Addiction at BMC, with 11 clinical programs for substance use disorders, is one of the nation's leading centers for addiction treatment, research, prevention, and education;
- Outpatient Mental Health Clinic, which includes the Addiction Psychiatry Treatment Program (APTP) and the Wellness and Recovery After Psychosis (WRAP) Program;
- Outpatient integrated mental health care within our pediatric and adult primary care clinics and at local community health center partners;
- Mental health urgent care clinic;
- Our Boston Emergency Services Team (BEST) provides community-based evaluations, a mental health crisis stabilization unit, and a jail diversion program;
- BMC Health System is in the process of constructing an 82-bed psychiatric facility in nearby Brockton, MA—including 56 inpatient psychiatric beds with the capacity to treat patients with co-occurring substance use disorder and 26 Clinical Stabilization Services (CSS) beds.

BMC has a particular expertise in connecting marginalized communities to health and social services and yet we still find it happens all too often that our **patients with co-occurring mental health and substance use disorders get stuck in a "revolving door,"** falling in and out of the MH/SUD treatment system, in many cases ending up on the streets, either episodically or chronically homeless, only to present repeatedly to our Emergency Department.

One of the issues at play is that the necessary supports for these patients are not in place:

- **Access to affordable, low-barrier housing:** For example, where you don't have to maintain sobriety to get a roof over your head. Not enough of these places exist. Though, BMC is in the very early stages of implementing this "housing first" approach, in partnership with the city of Boston, to get people living on the streets just steps from our hospital campus, oftentimes living with co-occurring MH/SUD, housed first, and then provide wrap-around medical services and social supports.
- **A good aftercare plan:** We think of care transitions as places where patients can fall through the cracks, e.g. leaving detox or an inpatient psychiatric facility to return to the community, but not linking up with outpatient treatment and support. The fact is, more needs to be done on either end to reach patients, understanding that addiction is a relapsing-remitting disease, and recovery is possible.
- **A supportive community:** When treating co-occurring MH/SUD, the goal is not necessarily to eliminate drug use completely, but how to use substances less so that a person can function in society—i.e. have a job and maintain healthy relationships with family and friends. At the same time, overemphasis on medication at the expense of other forms of treatment and support is likely not the answer. The question is really, how do we get people with co-occurring MH/SUD everything they need to survive and be healthy? For so many of our patients, particularly from multicultural/ethnic groups, connection to a supportive community is absolutely essential to recovery. From a care perspective, this can mean integrating community pillars like churches into care plans.

Substance use disorder is in the Diagnostic and Statistical Manual of Mental Disorders (DSM), the mental health field's principal authority for psychiatric diagnoses. It is estimated that about half of people with SUD will develop a MH disorder in their lifetime, and the same is true of people with MH disorders—about 50 percent

will develop a SUD in their lifetime.[1] For the patients we treat at BMC, we estimate that the percentage with co-occurring MH/SUD is likely even higher (55–60 percent). The idea that mental health and substance use disorders exist in separate siloes is reflected in how our treatment system is designed—but the distinction is artificial, and is not a reflection of how patients experience MH and SUD, or how as a physician I seek to treat MH and SUD.

As a Black, Spanish speaking psychiatrist, waivered to prescribe buprenorphine for opioid use disorder, I'm all too aware of the patients our treatment systems are failing to reach. Preliminary reports from the U.S. Centers for Disease Control and Prevention (CDC) indicate that the last year for which we have data was the deadliest on record, eclipsing 100,000 drug overdose deaths for the first time ever—a grim milestone.[2] While nationally overdose death rates have increased in every major demographic group in recent years, Black men have experienced the largest increases.[3] Even in Massachusetts, where we've seen population-wide drug overdose death rates level off in recent years, the death rates for Black men stand out in stark contrast, having increased an astounding 75 percent between 2019 and 2020 (from 32.6 to 57.1 per 100,000).[4] Communities of color are suffering disproportionately from COVID–19, and they are dying at disproportionate rates from SUD, bearing the brunt of two compounding public health crises. The COVID–19 pandemic has exacerbated all the inequities those of us practicing in mental health and SUD care have known for decades—workforce shortages, lack of coordinated care, lack of parity, and low reimbursement.

At the same time, Black men have comparably low rates of MH/SUD treatment. Racism and discrimination in all facets of life for these communities have not only made accessing care difficult, but once in treatment, unfair and inequitable systems and practices cause folks to quickly disengage from the treatment they so rightly deserve and need in order to recover.

At BMC, we have launched the Health Equity Accelerator to eliminate the race-based health equity gap by utilizing data-driven and community-based research to inform and change the way we approach care for Black people and people of color.[5] We are going directly to people in the community for answers and centering their experience seeking MH/SUD treatment to inform our interventions and programming moving forward.

While we don't yet have the answers we seek, we do know that a one-size-fits-all approach doesn't work and that access is strained across the MH/SUD continuum. That is why reauthorizing funding to support states and localities responding to MH and SUD crises in flexible ways is crucial including through **State Opioid Response Grants, Substance Abuse Prevention and Treatment Block Grants**, and **Community Mental Health Services Block Grants**. Thank you to the Senate HELP Committee for your commitment to coming together on a bipartisan basis to sustain funding in these critical programs over time.

I would like to end with providing a glimpse into the reality of what our patients face every day. In one of my recent shifts in our psychiatric emergency room, a man in his late 20's came in seeking help for his mental health and substance use disorder. In our short time together, he described his onset of opioid use at 9 years of age—his parents were both using substances and there was minimal supervision in the home. As we see often, the patient had experienced years of substance use, time in the carceral system, death of many family members, and unsuccessful relationships with limited to no supports. He has been in and out of treatment over the years as well, but a system that does not allow relapse, a system that does not coordinate care, a system that stigmatizes substance use, a system that criminalizes

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[1] National Institute on Drug Abuse (NIDA) Common Comorbidities with Substance Use Disorders Research Report—Part 1: The Connection Between Substance Use Disorders and Mental Illness, April 13, 2021.*https://nida.nih.gov/publications/research—reports/common—comorbidities—substance—use—disorders/part–1—connection—between—substance—use—disorders-mental-illness*

[2] U.S. Centers for Disease Control and Prevention, National Center for Health Statistics. Drug Overdose Deaths in the U.S. Top 100,000 Annually. November 17, 2021. *https://www.cdc.gov/nchs/pressroom/nchs—press—releases/2021/20211117.htm*

[3] Gramlich J. Recent surge in U.S. drug overdose deaths has hit Black men the hardest. Pew Research Center. January 19, 2022. *https://www.pewresearch.org/fact-tank/2022/01/19/recent-surge-in-u-s-drug-overdose-deaths-has-hit-black-men-the-hardest/*

[4] Massachusetts Department of Public Health. Opioid-Related Overdose Deaths, All Intents, MA Residents—Demographic Data Highlights. November 2021. *https://www.mass.gov/doc/opioid-related-overdose-deaths-demographics-november–2021/download*

[5] Dayal McCluskey P. Boston Medical Center launches new plan to address racial disparities in health care. Boston Globe. November 16, 2021. *https://www.bostonglobe.com/2021/11/16/metro/boston-medical-center-launches-new-plan-addressing-racial-disparities-health-care/*

substance use ultimately exacerbates issues and prevents people from being able to recover and live healthy, fulfilling lives.

Because whether we're talking about mental health or substance use disorders, or co-occurring MH/SUD, I think the question we're seeking to answer is how do we as a society continue to see the humanity in people with mental illness and/or who are using substances, and shape our policies and programs intended to treat and support people with MH/SUD accordingly.

Thank you for your time. I look forward to the discussion.

[SUMMARY STATEMENT OF MICHELLE P. DURHAM]

In my over 10 years at Boston Medical Center (BMC), an academic medical center and the region's largest safety-net hospital, I have never seen our mental health care services stretched so far beyond their capacity as they are now. Since late December 2021, we have had 30-plus patients in our Psychiatric Emergency Department—more than three to four times its capacity—presenting with a much higher level of acuity, some waiting for evaluation and others boarding awaiting placement in an inpatient psychiatric unit.

BMC has a particular expertise in connecting marginalized communities to health and social services and yet we still find it happens all too often that our patients with co-occurring mental health (MH) and substance use disorders (SUD) get stuck in a "revolving door," falling in and out of the MH/SUD treatment system, in many cases ending up on the streets, either episodically or chronically homeless, only to present repeatedly to our Emergency Department.

One of the issues at play is that the necessary supports for these patients are not in place, including affordable, low-barrier housing and coordinated care integrated with a supportive community. The question is really, how do we get people with co-occurring MH/SUD everything they need to survive and be healthy?

As a Black, Spanish speaking psychiatrist, waivered to prescribe buprenorphine for opioid use disorder, I'm all too aware of the patients our treatment systems are failing to reach. Preliminary reports from the CDC indicate that the U.S. has eclipsed 100,000 annual drug overdose deaths for the first time ever. While nationally overdose death rates have increased in every major demographic group in recent years, Black men have experienced the largest increases. Even in Massachusetts, where we've seen population-wide drug overdose death rates level off in recent years, the death rates for Black men stand out in stark contrast, having increased an astounding 75 percent between 2019 and 2020. Communities of color are suffering disproportionately from COVID–19, and they are dying at disproportionate rates from SUD, bearing the brunt of two compounding public health crises. At the same time, Black men have comparably low rates of MH/SUD treatment.

At BMC, we have launched the Health Equity Accelerator to eliminate the race-based health equity gap by utilizing data-driven and community-based research to inform and change the way we approach care for Black people and people of color. While we don't yet have the answers we seek, we do know that a one-size-fits-all approach doesn't work and that access is strained across the MH/SUD continuum. That is why reauthorizing funding to support states and localities responding to MH and SUD crises in flexible ways is crucial. Thank you to the Senate HELP Committee for your commitment to coming together on a bipartisan basis to sustain funding in these critical programs over time.

In order to make progress, we must work to transform our MH/SUD care system into one that recognizes relapse as a reality, coordinates care, destigmatizes and decriminalizes substance use, and ultimately, one that sees the humanity in people with MH/SUD and enables them to recover and live healthy, fulfilling lives.

The CHAIR. Thank you very much.

Director Goldsby.

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

Ms. GOLDSBY. Good morning, Chair Murray, Ranking Member Burr, Senator Murkowski, and Members of the Committee. My name is Sara Goldsby and I serve as Director of South Carolina's

Department of Alcohol and Other Drug Abuse Services. I also serve as President of the National Association of State Alcohol and Drug Abuse Directors, or NASADAD, and it is a privilege to join you today.

I would like to begin by thanking you for your work to pass the Comprehensive Addiction and Recovery Act, or CARA, and the 21st Century Cures Act and the Support Act. In addition, thank you for providing historic Federal investments and programs housed within the Substance Abuse and Mental Health Services Administration, including the Substance Abuse Prevention and Treatment or SAPT Block Grant.

As you mentioned earlier, our country continues to experience the devastating impact of substance use disorders, and the number of overdose deaths is simply staggering. In my home State of South Carolina, overdose deaths have increased by 60 percent over the last 5 years, and more of those deaths occurred in the last 2 years, with the increased use during COVID–19, and the incredibly potent illicit fentanyl supply we have been inundated with.

Overall, almost one-third of individuals admitted to treatment in our country's publicly funded addiction system, excuse me, cited heroin or prescription opioids as their primary substance abuse. Yet we also know substance use disorders impact different States, counties, and communities in different ways. In South Carolina, for example, we are seeing a rise in admissions to treatment for alcohol use disorder, where 42 percent of people admitted to treatment reported alcohol as their primary problem.

There is no doubt that the COVID–19 pandemic contributed to increases in problems related to substance use disorders, yet we have all worked to adjust. States and providers have developed innovative approaches to prevention, treatment, and recovery programing. Federal agencies and Congress have worked to provide important flexibilities through program guidance and communication.

In addition, Congress and the Administration worked to provide critical funding for prevention, treatment, and recovery, along with lifesaving overdose reversal medication. As I observe the work moving forward in the field, I continue to be amazed and inspired by the incredible commitment, courage, and resolve that I see on a daily basis. I am particularly grateful for our frontline providers.

Even though they are exhausted, they are stretched thin, they continue to serve, they continue to help, and they continue to save lives, and they continue to help find a road for recovery for everyone they serve. And I offer a number of recommendations as we continue our work together. First, we ask that Federal policy ensures a strong SAMHSA as the lead Federal agency on substance use disorders service delivery.

We believe SAMHSA should be the default agency for all Federal substance use disorder programing, and we applaud Dr. Miriam Delphin-Rittmon, Assistant Secretary for Mental Health and Substance Use as a leader of SAMHSA. Second, please work to ensure that Federal policy initiatives and Federal funding for substance use disorders flows through State alcohol and drug agencies, given our work to ensure quality and evidence based services, and to en-

sure effective planning, implementation, oversight, and accountability.

Third, we hope for continued support of the SAPT Block grant. The flexibility afforded in the Block grant allows States to target resources where they are needed more based on data and the conditions on the ground. Our country faces a giant workforce problem. We are struggling to find people to do the job. And while we appreciate HRSA, we need an all hands on deck approach.

We can—we hope this Committee will give SAMHSA and its programs full statutory authority to immediately help with our workforce challenges. We appreciate this Committee's work to help reduce suicide and improve our Nation's response to people experiencing crisis. Since this time, SAMHSA has been actively working with stakeholders to prepare for the July 2022 launch of 988. And as we move forward, we ask that Congress and others specifically elevate and specifically reference substance use disorders as a core focus of work related to crisis response.

We believe this approach is needed given the many distinct and unique considerations that accompany service delivery for people with substance use disorders and substance driven crisis. Finally, we hope Congress continues to work with stakeholders and the Administration to maintain certain flexibilities that were granted in connection with the public health emergency.

I am happy to review other recommendations with the Committee as time permits. In the meantime, thank you for the opportunity to testify today, and I look forward to questions you may have.

[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 the Director of the South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS). I also serve as the President of the National Association of State Alcohol and Drug Abuse Directors (NASADAD). NASADAD represents State agency directors across the country that manage their respective State alcohol and drug prevention, treatment, and recovery systems.

It is an honor to testify before you today regarding the ways in which the Federal Government, states, communities, and families have been working together to address substance use disorders. I appreciate the opportunity to share perspectives.

We continue to see the devastating impact of substance use disorders across the country. The number of overdose deaths is staggering. In 2020, 93,331 individuals died from drug overdoses in the United States, the highest number ever recorded in a 12-month period and a 30 percent increase from 2019. Approximately 75 percent of overdose deaths involved synthetic opioids and illegally manufactured fentanyl (Centers for Disease Control and Prevention (CDC), 2021). In my home State of South Carolina, overdose deaths have increased by 60 percent over the past 5 years.

Overall, almost one-third (30.3 percent) of individuals admitted to treatment in our country's publicly funded addiction system cited heroin or prescription opioids as their primary substance of use (TEDS/SAMHSA, 2019). We also know substance use disorders impact different States, counties, and communities in many different ways. In South Carolina, for example, we are seeing a rise in admissions to treatment for alcohol use disorder. In particular, approximately 42 percent of treatment admissions reported a primary substance of alcohol or alcohol with a secondary drug (TEDS/SAMHSA, 2019).

There is no doubt that the COVID–19 pandemic contributed to increases in problems related to substance use disorders. For example, the National Institute on Drug Abuse (NIDA) cited research that found increases in the number of positive

urine drug tests ordered by health care providers and legal systems (NIDA, 2022). The reports analyzing the drug screen results indicated an increase in fentanyl, cocaine, heroin, and methamphetamine compared to previous years (NIDA, 2022).

While the pandemic presented challenges to service delivery, we all worked together to adjust. States and providers developed innovative approaches to prevention, treatment, and recovery programming. Federal agencies and Congress worked to provide States and providers important flexibilities through program guidance and communication. In addition, Congress and the Administration worked to provide critical funding for prevention, treatment, and recovery along with life-saving overdose reversal medication. I had the privilege of testifying before this Committee in April •21 to share some of this work.

There is no doubt that the pandemic continues to present challenges. We have a great deal of work ahead of us.

Please know that the support from this Committee, the House, the Senate, and the Administration has been vital. Thank you.

As I observe the work moving forward in the field, I continue to be amazed and inspired by the incredible commitment, courage, and resolve I see on a daily basis. I am particularly grateful for our front-line providers. Even though they are exhausted and stretched thin, they continue to serve; they continue to help; they continue to save lives; and they continue to improve lives. We should all find a moment to thank and recognize our providers any chance we get.

I will review a number of recommendations for the Committee's consideration at the end of my remarks. All of these observations are critical. At the same time, it is my hope that extra energy is directed at addressing the many challenges related to our nation's substance use disorder workforce.

Critical Role of the State Alcohol and Drug Agency: I would like to step back and describe the role of each State's alcohol and drug agency. These agencies oversee and implement 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 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.

Working to support providers to ensure quality and delivery of evidence-based practices: 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 accreditation 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 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 on programs and services across prevention, treatment and recovery: 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 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.

Communicating with, and acquiring input from, providers and local communities and stakeholders: 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 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.

State alcohol and drug agencies appreciate action taken by Congress to address substance use disorders in general, and the opioid crisis: NASADAD is appreciative of this Committee, along with Congress and the Administration in general, for the work done to address substance use disorders in general, and the opioid crisis in particular. In addition, we appreciate passage of the Comprehensive Addiction and Recovery Act (CARA), 21st Century Cures Act, and the SUPPORT Act.

We highlight a few of the many programs below:

Substance Abuse Prevention and Treatment (SAPT) Block Grant (21st Century Cures, Section 8002): The SAPT Block Grant is NASADAD's No. 1 programmatic priority. This program is the cornerstone of States' substance use disorder preven-

tion, treatment, and recovery systems. The SAPT Block Grant serves approximately 2 million people annually.

Federal statute requires State alcohol and drug agencies to allocate at least 20 percent of SAPT Block Grant funds toward primary substance use prevention. This "prevention set-aside" is a core component of each State's prevention system. In particular, SAPT Block Grant funds make up more than 60 percent of primary prevention funds managed by State alcohol and drug agencies. In 14 States, the prevention set-aside represents 75 percent or more of the State agency's substance use prevention budget. In six States, the prevention set-aside represents 100 percent of the State's primary prevention funding.

We sincerely appreciate recent action by Congress to allocate historic investments in the SAPT Block Grant. These investments were made in the fiscal year 2021 omnibus appropriations bill (P.L. 116–260) and subsequently in the American Rescue Plan (P.L. 117–2). Prior to these significant investments, the SAPT Block Grant remained essentially level-funded for a number of years. In particular, from 2011 to 2021, SAPT Block Grant funding did not keep up with health care inflation, resulting in a 24 percent decrease in purchasing power.

Account for the State Response to the Opioid Crisis (21st Century Cures, Section 1003): We sincerely appreciate the creation of an account for the State opioid response to the opioid crisis (Section 1003). This $1 billion fund for fiscal year 2017 and fiscal year 2018 helped State alcohol and drug agencies to significantly enhance treatment, prevention, and recovery services along with overdose reversal activities. This funding, initially known as the State Targeted Response to the Opioid Crisis Grants (STR), now known as the State Opioid Response Grants (SOR), provided a substantial level of support for innovative and lifesaving programs in States across the country. The Substance-Use Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act re-affirmed the importance of grants to States to address the opioid crisis through Section 7181.

Priority substance abuse treatment needs of regional and national significance within SAMHSA's Center for Substance Abuse Treatment (CSAT) (21st Century Cures, Section 7004): CSAT works closely with State alcohol and drug agencies to help expand access to treatment for and recovery from substance use disorders. CSAT focuses on work to improve the quality of substance use treatment services through its Addiction Technology Transfer Center (ATTC). NASADAD recognizes Dr. Ingvild Olsen, Acting Director of CSAT, for her leadership of the Center. Further, we wish to recognize the Division of State and Community Assistance (DSCA) for their support of NASADAD's members in working to implement State-based awards including the Substance Abuse Prevention and Treatment (SAPT) Block Grant. In addition, the Division of Pharmacologic Therapies (DPT) is a key component of SAMHSA that works with State Opioid Treatment Authorities (SOTAs) and State agency directors to ensure effective programming related to medications for substance use disorders, including those moving forward within our nation's opioid treatment programs (OTPs).

Priority substance abuse prevention needs of regional and national significance within SAMHSA's Center for Substance Abuse Prevention (CSAP) (21st Century Cures, Section 7005): As noted by SAMHSA, CSAP provides national leadership in the development of programs, policies, and services to prevent the onset of illegal drug use, prescription drug misuse, and underage alcohol use and tobacco use. CSAP also works to help promote evidence-based practices through structures like the Prevention Technology Transfer Centers (PTTC). We applaud Dr. Jeff Coady, Acting Director of CSAP, for his direction. In addition, we recognize CSAP's Division of Primary Prevention (DPP) for their work with States.

A NASADAD priority program within CSAP is the Strategic Prevention Framework—Partnerships for Success (SPF-PFS) initiative. This program allows State alcohol and drug agencies to utilize cross-agency collaboration to address prevention priorities through a data-driven process. State alcohol and drug agencies partner with anti-drug coalitions to implement this important work at the local level. At the national level, NASADAD partners the Community Anti-Drug Coalitions of America (CADCA) to help foster these relationships and promote best practices in prevention.

Evidence-based prescription opioid and heroin treatment and interventions demonstration grants (CARA, Section 301): The evidence-based opioid and heroin treatment and interventions demonstration grant was authorized in CARA to help State alcohol and drug agencies increase access to Food and Drug Administration-approved medications for opioid use disorders in order to ensure clinically appropriate care. The authorization requires SAMHSA to fund only those applications that specifically support recovery services as a critical component of the program involved.

Improving Treatment for Pregnant and Postpartum Women (CARA, Section 501 and SUPPORT Act, Section 7062): CARA reauthorized the Residential Treatment for Pregnant and Postpartum Women program to help support comprehensive, family centered treatment services where women and their children can receive the help they need together in a residential setting. CARA also created a pilot program to afford State alcohol and drug agencies flexibility in providing new and innovative family centered substance use disorder services in non-residential settings. The SUPPORT Act reauthorized both programs from 2019—2023 and increased the funding level from an authorization of $16.9 million to $29.9 million.

Community Coalition Enhancement Grants (CARA, Section 103): This section authorized the Office of National Drug Control Policy (ONDCP), that coordinates with Centers for Disease Control and Prevention (CDC), to make grants to community anti-drug coalitions to implement community-wide strategies to address their local opioid and methamphetamine problem. States work with community anti-drug coalitions daily to engage in key primary prevention efforts at the local level.

Building Communities of Recovery (CARA, Section 302): The BCOR initiative authorized SAMHSA to award grants to recovery community organizations (RCOs) to develop, expand and enhance recovery services. RCOs across the country are doing an excellent job of helping persons in recovery regain positive and productive relationships with their families, employers, and communities. NASADAD is a strong partner of Faces and Voices of Recovery (FAVOR) and its Association of Recovery Community Organizations (ARCO) as efforts are made to expand access to recovery support services in the publicly funded system.

Medicare Coverage of Certain Services Furnished by Opioid Treatment Programs (Section 2005, SUPPORT Act): This section amended the Social Security Act to expand Medicare coverage to include treatment services provided by SAMHSA-certified opioid treatment programs (OTPs). The covered services include medication assisted treatment (MAT), counseling, drug testing, and individual and group therapy.

Plans of Safe Care (SUPPORT Act, Section 406): This provision amended the Child Abuse Prevention and Treatment Act (CAPTA) to make grants to help State child welfare agencies, State alcohol and drug agencies and others facilitate collaboration in developing, updating and implementing plans of safe care. Plans of safe care are tools that inventory and direct services and supports to ensure the safety and well-being of an infant impacted by substance use disorders, withdrawal, or fetal alcohol spectrum disorders, including services for the infant and their family/caregiver. The grant funds may also be used to support developing agency-to-agency memoranda of understanding (MOU), training, developing and updating technology to improve data collection, and more.

Recommendations for Consideration

Promote and ensure a strong SAMHSA that serves as the lead Federal agency across the Federal Government on substance use disorder service delivery: 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. A strong SAMHSA includes a vibrant role for each of its centers—the Center for Substance Abuse Treatment (CSAT), Center for Substance Abuse Prevention (CSAP), Center for Mental Health Services (CMHS), and Center for Behavioral Health Statistics and Quality (CBHSQ).

NASADAD expresses our support for Dr. Miriam E. Delphin-Rittmon, Assistant Secretary for Mental Health and Substance Use and leader of SAMHSA, as she guides the agency and works across HHS to promote a unified Federal approach to substance use disorders. We strongly believe SAMHSA should be the default home of substance use disorder discretionary grants and programming related to prevention, treatment, and recovery. This requires financial resources but also the human resources needed to provide this leadership.

Ensure that Federal policy and resources related to substance use disorders are routed through the State alcohol and drug agency: State alcohol and drug agencies play a critical role in overseeing and implementing a coordinated prevention, treatment, and recovery service-delivery system. 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. Finally, NASADAD members promote and ensure quality through standards of care, technical assistance to providers, and other

tools. As a result, NASADAD prefers 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 or even duplicative publicly funded systems and approaches.

Continued investment in the Substance Abuse Prevention and Treatment (SAPT) Block Grant while maintaining maximum flexibility: NASADAD's top programmatic discretionary grant program priority is the Substance Abuse Prevention and Treatment (SAPT) Block Grant. We sincerely appreciate the work of this Committee on this important program. In addition, we appreciate recent historic financial investments made by Congress in the SAPT Block Grant. In the context of reauthorization, NASADAD prefers to maintain as much flexibility as possible in the use of SAPT Block Grant funds consistent with the nature of, and benefits related to, the block grant mechanism. The flexibility afforded in the SAPT Block Grant allows States the opportunity to target resources based on the conditions on the ground as opposed to pre-ordained spending requirements.

Promote sustained and predictable funds through three-to 5-year discretionary grants: In addition to adequate resources, State alcohol and drug agencies note that sustained and predictable resources are absolutely critical. They allow States to partner with sub-State entities, providers, and others to plan activities in a systematic manner. One-and 2-year programs, with only a short-term commitment, can create an environment of uncertainty related to the future of a critical initiative that provides lifesaving services. It can be difficult, if not impossible, to successfully plan and operate programs with an eye on continuity of services if providers are not confident that resources will be available to serve their patients. NASADAD strongly supports the National Governors Association's (NGA) call to extend the duration of Federal grants beyond the typical one-or 2-year funding cycle to either a three-or 5-year cycle.

Ensure new Federal initiatives and funding complement and enhance the current system: NASADAD appreciates the many Federal legislative efforts to address substance use disorders that were found in the Comprehensive Addiction and Recovery Act (CARA), 21st Century Cures Act, and the SUPPORT Act. In the process, the Association has been partnering with Congress, the Administration, and non-governmental organizations to implement many of these initiatives. This includes work related to program management and implementation, data collection/reporting, and engagement in the many day-to-day activities that ensure programs are managed effectively and efficiently. As a result, we recommend policies that complement or enhance the work that has already been done in order to leverage our collective response in an efficient and effective manner.

Continue to work to address the opioid crisis but also elevate efforts to address all substance use disorders, including those linked to alcohol and other substances: The opioid crisis is one of the worst public health tragedies in our nation's history. The sheer volume of death linked to this epidemic is difficult to grasp. We also know this country faces distinct challenges related to all substances whether it is prescription drug misuse, heroin, alcohol, marijuana, methamphetamine, cocaine or others. According to SAMHSA's National Survey on Drug Use and Health (NSDUH), alcohol remains a distinct problem in the country, with 28.3 million Americans battling an alcohol use disorder. As we look at those receiving publicly funded treatment, 31 percent of all admissions to treatment had a primary alcohol use disorder; 30 percent had a primary heroin or other opiate problem; and 11 percent had primary marijuana use disorder. State directors in certain States are also observing increases in problems related to methamphetamine and cocaine. As a result, NASADAD promotes policies and grant programs that are flexible yet also address the specific needs associated with the current opioid crisis. The flexibility included in the SAPT Block Grant also affords States the opportunity to target resources to address all substances.

Provide SAMHSA the authority and resources to help address the nation's substance use disorder workforce crisis: State alcohol and drug agency directors across the country are observing distinct workforce challenges. Quite simply, my colleagues note difficulties finding enough people to support prevention, treatment, and recovery programming. We understand the issue is complex. We also know there are many steps that need to be taken to buildup our workforce to meet the variety of needs related to substance use disorders. These steps include initiatives around recruitment, access to all levels of education, training, retention, salaries, and continuing education. There are strategies that can help loan repayment;

scholarships; and early outreach in schools promoting a career that helps address substance use prevention, treatment and recovery. We recommend action to give SAMHSA the full statutory authority to help address our challenges related to the substance use disorder workforce. This includes action clarifying that SAPT Block Grant funds may be used to help States address workforce needs. Further, we support a specific proposal in CARA 3.0—Section 211—that would authorize a grant in SAMHSA's CSAP to State alcohol and drug agencies in order to bolster our nation's substance use prevention workforce needs as we are not aware of any Federal programs that currently address this.

Ensure that initiatives designed to implement 988 and crisis services improvement to specifically include programs and strategies to address substance use disorders: In 2020, the National Suicide Hotline Designation Act of 2020 was signed into law. The Act incorporated 988 as the new National Suicide Prevention Line (NSPL) and Veterans Crisis Line (VCL). We wish to express our appreciation for working to draft and approve this important piece of legislation to help reduce the number of suicides and improve our response to people experiencing a crisis. Since this time, SAMHSA has been actively working with stakeholders to prepare for the July 2022 launch of 988. This work includes the release of funds designed to help strengthen and expand existing Lifeline operations and telephone infrastructure along with funds to buildup staffing across States' local crisis call centers.

SAMHSA is partnering with States, providers, people with lived experience, and others to hold convenings in an effort to prepare for 988. These efforts include the complex task of strengthening our nation's service-delivery system for crisis services. We understand the launch of 988 is the beginning of a long journey that promises to help improve our approach to helping people experiencing a crisis. As we move forward, we ask that Congress and others elevate and specifically reference substance use disorders as a core focus of work related to crisis response. We believe this approach is needed given the many distinct and unique considerations that accompany service delivery for people with substance use disorders.

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 COVID–19 pandemic should be maintained at least 1 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 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.

State alcohol and drug agencies play a critical role in the prevention, treatment, and recovery of substance use disorders and I look forward to working with the Committee on ways the Federal Government, States, communities, and families can work together to address this very important issue.

Thank you again for the opportunity to testify today and share my perspective. I look forward to any questions you may have.

[SUMMARY STATEMENT OF SARA GOLDSBY]

Continued challenges with overdose deaths: Our country continues to see the devastating impact of substance use disorders across the country. The number of overdose deaths is staggering. In 2020, 93,331 individuals died from drug overdoses in the United States, the highest number ever recorded in a 12-month period and a 30 percent increase from 2019. Approximately 75 percent of overdose deaths involved synthetic opioids and illegally manufactured fentanyl (Centers for Disease Control and Prevention (CDC), 2021). In my home State of South Carolina, overdose deaths have increased by 60 percent over the past 5 years.

Challenges with many substances: Overall, almost one-third (30.3 percent) of individuals admitted to treatment in our country's publicly funded addiction system cited heroin or prescription opioids as their primary substance of use (TEDS/SAMHSA, 2019). We also know substance use disorders impact different States, counties, and communities in many different ways. In South Carolina, for example, we are seeing a rise in admissions to treatment for alcohol use disorder. In particular, approximately 42 percent of treatment admissions reported a primary substance of alcohol or alcohol with a secondary drug (TEDS/SAMHSA, 2019).

Working through the pandemic: There is no doubt that the COVID–19 pandemic contributed to increases in problems related to substance use disorders. While the pandemic presented challenges to service delivery, we all worked together to adjust. States and providers developed innovative approaches to prevention, treatment, and recovery programming. Federal agencies and Congress worked to provide States and providers important flexibilities through program guidance and communication. In addition, Congress and the Administration worked to provide critical funding for prevention, treatment, and recovery along with life-saving overdose reversal medication. I had the privilege of testifying before this Committee in April •21 to share some of this work.

Extra support and attention to help workforce challenges: I offer a number of recommendations below as we continue this work. All of these observations are critical. At the same time, it is my hope that extra energy is directed at addressing the many challenges related to our nation's substance use disorder workforce.

Recommendations:

- Ensure that Federal policy and resources related to substance use disorders are routed through the State alcohol and drug agency
- Promote and ensure a strong SAMHSA that serves as the lead Federal agency across the Federal Government on substance use disorder service delivery
- Provide SAMHSA the authority and resources to help address the nation's substance use disorder workforce crisis
- Ensure that initiatives designed to implement 988 and crisis services improvement to specifically include programs and strategies to address substance use disorders
- Promote sustained and predictable funds through three-to 5-year discretionary grants
- Continue to work to address the opioid crisis but also elevate efforts to address all substance use disorders, including those linked to alcohol and other substances
- Maintain Recent Flexibilities to Ensure Access to Substance Use Disorder Services

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The CHAIR. Thank you.
Dr. Lockman.

STATEMENT OF JENNIFER D. LOCKMAN, PH.D., CEO, CENTERSTONE RESEARCH INSTITUTE, NASHVILLE, TN

Ms. LOCKMAN. Thank you.

The CHAIR. You want to make sure your mic is on?

Ms. LOCKMAN. Can you hear me now?

The CHAIR. No. We have a staff person—or Senator Burr?

Ms. LOCKMAN. Is that okay?

The CHAIR. There you go. Yes——

Ms. LOCKMAN. Okay, thank you for the help. I would like to thank Chair Murray and Ranking Member Burr and this Committee for your dedication to seeking solutions to the growing mental health and substance use crisis our country is facing today.

I would also like to thank Senator Braun for his leadership for the State of Indiana, which is one of the States we are proud to serve in. I am honored to be here as the voice of my colleagues at Centerstone, and most importantly on behalf of the people we serve. Centerstone is the Nation's largest nonprofit mental health company. Centerstone provides community based behavioral health care, substance abuse treatment, and intellectual and developmental disability services.

At Centerstone Research Institute, a Centerstone company, we conduct research to prevent and cure mental illness and addiction. We also work to translate data into meaningful clinical tools and practices, thereby reducing the research to practice gap. We applaud this hearing today because unfortunately deaths due to suicide, overdose, and drug and alcohol related disease are all too prevalent. As of 2020, suicide was the 12th leading cause of death in the United States for adults and the third leading cause of death for youth.

Between 40 percent and 50 percent of Americans have been exposed to suicide during their lifetime. This means that at least half of us sitting in this room today are likely to have been personally affected by the loss of someone that we loved to suicide. For this reason, Congress, in partnership with the Substance Abuse and Mental Health Services Administration, created the Garrett Lee Smith National Strategy for Suicide Prevention, Zero Suicide, and COVID–19 Emergency Response suicide prevention grants.

Centerstone Health Care System is honored to share our experience and the outcomes from some of our SAMHSA grants we have received. For our Zero Suicide SAMHSA grant, we are now working to spread evidence based practices known to decrease suicide throughout our entire health system and using data to make them even better. For example, we have updated our suicide prevention pathway to ensure everyone in our health care system gets evidence based suicide screening, risk management, and treatment.

We have moved toward a new screening system that first asks more about upstream risk factors for suicide, such as thwarted belongingness, perceived burdensomeness, and acquired capability for suicide, and then also asked about suicide directly through the PHQ–9 and C-SSRS. We anticipate the screening process helps us identify and treat drivers of suicide risk earlier and with better outcomes. We have also piloted a suicide prevention specialty care clinic, the first known and community mental health centers in the United States.

We expect all of our Centerstone clinicians to be able to identify and treat suicide risk. However, it is difficult and costly to keep all of our clinicians up to date on suicide specific treatments as fast as the science changes. In medicine, we have seen that people often get better outcomes at cost when at high risk by seeing medical specialists like cardiologists and oncologists.

Thus, through our grant, we are creating a referral system so that persons at the highest risk for suicide can also be seen by a specialist, someone who is trained in multiple suicide specific treatments, the very best that science has to offer. Our grants have also provided a crisis follow-up program for youth and adults during care transitions from inpatient facilities, a high risk period for suicide attempts and re-attempts.

Our data suggest this Federal program helps individuals reestablish connectedness, decrease their sense of burdensomeness, reduce suicidal ideation, and successfully linked to outpatient care 70 to 90 percent of the time. These services would be unbillable and impossible without the Federal SAMHSA grants.

Knowing this program works to save lives is especially timely given the July 2022 launch of 988 as a three digit dialing code for the National Suicide Prevention Lifeline. As we look toward launching 988, we must also continue to evaluate strategies to ensure services are funded and available nationally. This is why we also support the Behavioral Health Crisis Services Expansion Act as a crucial component to financing a crisis care continuum.

Another grant program that has been a lifeline is a Certified Community Behavioral Health Clinic, Medicaid demonstration, and CCBHC SAMHSA grant program. CCBHCs allow consistent care for those with mental health or substance use conditions and a place to go in times of crisis. This model is helping to address some of the dire workforce challenges our field has faced even prior to the pandemic.

We recommend continued investment in the CCBHC program. Centerstone is also pleased to be one of the only few comprehensive opioid recovery center grant recipients in the Nation. We recommend continued investment in this promising program. Of all the things you might take away from my testimony today, please be sure to hear this, Federal funding works. Federal funding saves lives. Federal funding helps prevent suicide and substance related deaths, uses program evaluation to help make evidence based programs even better, and helps individuals recover and contribute in their communities.

In the words of one of our clients, "there is no way to define a future if you are not there for it, and everyone is really focused on making sure that you stay there for it. Stay alive, stay safe. It has been really helpful for me to develop my own path. It has made a lot of difference."

It has been one of the great joys of my life to watch people go from a place of deep despair to go on to rediscover their talents, their strengths, and go on to build a life that they really want to live. Thank you, and I look forward to your questions.

[The prepared statement of Ms. Lockman follows:]

PREPARED STATEMENT OF JENNIFER LOCKMAN

I would like to thank Chair Murray and Ranking Member Burr and this Committee for your dedication to seeking solutions to the growing mental health and substance use crisis our country is facing today. I'd also like to thank Senator Braun for his leadership for the State of Indiana, which is one of the states we are proud to serve in. I'm honored to be here as the voice of my colleagues at Centerstone and most importantly on behalf of the people we serve.

Centerstone is the nation's largest nonprofit mental health company. Centerstone provides community-based behavioral health care, substance-abuse treatment, and intellectual and developmental disabilities services in Florida, Illinois, Indiana, and Tennessee. At Centerstone's Research Institute (CRI), a Centerstone company, we conduct research to prevent and cure mental illness and addiction. We also work to translate data into meaningful clinical tools and practices, thereby reducing the research-to-practice gap.

We applaud this hearing today because unfortunately, deaths due to suicide, overdose, and drug and alcohol related disease are all too prevalent. As of 2020, suicide was the 12th leading cause of death in the United States for adults, and the 3d leading cause of death for youth. For every suicide death, there are approximately 1.1 million suicide attempts, or about one every 27.5 seconds (Drapeau & McIntosh, 2021). Between 40 percent to 50 percent of Americans have been exposed to suicide during their lifetime (Cerel et al., 2014; Feigelman et al., 2017). This means that at least half of us sitting in this room today are likely to have been personally af-

fected by the loss of someone we loved to suicide. Although suicide deaths decreased approximately 3.4 percent between 2019 and 2020, perhaps due to a "pulling together effect" we have seen before during national crises, the deeply painful impact of suicide deaths on American individuals, families, and communities remains high (Drapeau & McIntosh, 2021; Joiner et al., 2006).

For this reason, Congress in partnership with the Substance Abuse and Mental Health Services Administration (SAMHSA) created the Garrett Lee Smith, National Strategies for Suicide Prevention, Zero Suicide, and Covid–19 Emergency Response suicide prevention grants. Centerstone's healthcare system is honored to share our experience and the outcomes from some of the SAMHSA grants that we have received.

Through our Zero Suicide SAMHSA grant, we are now working to spread evidence-based practices known to decrease suicide throughout our entire health system, and using data to make them even better. For example, we have updated our Suicide Prevention Pathway to ensure everyone in our healthcare system gets evidence-based suicide screening, risk management, and treatment. We have moved toward a new screening system that first asks about more "upstream" risk factors for suicide (such as thwarted belongingness, perceived burdensomeness, and acquired capability for suicide; Joiner et al., 2005), and then asks about suicide directly (PHQ–9; C-SSRS). We anticipate this screening process helps us identify and treat drivers of suicide risk earlier, with better outcomes (Louzon et al., 2016: Richards et al., 2019).

We have also piloted a suicide prevention specialty care clinic, the first known in Community Mental Health Centers in the United States. We expect all of our Centerstone clinicians to be able to identify and treat suicide risk; however, it is difficult and costly to keep all of our clinicians up to date on suicide-specific treatments as fast as the science changes. In medicine, we have seen that people often get better outcomes at cost, when at high risk, by seeing medical specialists (e.g., cardiologists, oncologists). Thus, through our grant, we are creating a referral system so that persons at the highest risk for suicide can be seen by providers who are trained in multiple suicide-specific treatments—the best that science has to offer.

Our grants have also provided a Crisis follow-up program to youth and adults during care transitions from inpatient facilities, a high-risk period for suicide attempts and re-attempts (Chung et al., 2017). Our data suggest this program helps individuals re-establish connectedness, decrease their sense of burdensomeness, reduce suicidal ideation, and successfully link to outpatient care (70–90 percent of the time). These services would be unbillable, and impossible, without the Federal SAMHSA grants. Knowing this program works to save lives is especially timely given the July 2022 launch of "988" as the three-digit dialing code for the National Suicide Prevention Lifeline (NSPL). As we look toward launching 988 we must also continue to evaluate strategies to ensure these data-supported services are funded and available nationally. This is why we also support the Behavioral Health Services Crisis Expansion Act (S. 1902) as a crucial component to financing a crisis care continuum.

Another grant program that has been a lifeline is the Certified Community Behavioral Health Clinic (CCBHCs) Medicaid demonstration and CCBHC SAMHSA grant program. CCBHCs allow consistent care for those with mental health or substance use conditions and a place to go in times of crisis. This model is helping to address some of the dire workforce challenges our field has faced even prior to the pandemic. We recommend continued investment in the CCBHC program. Centerstone is also pleased to be one of only a few Comprehensive Opioid Recovery Center grant recipients in the Nation. We administer this grant in Indiana, where we were able to train over 467 professionals in evidence-based practices and open a recovery house for women. We recommend continued investment in this promising program.

Out of all the things you might take away from my testimony today please be sure to hear this: Federal funding works. Federal funding helps prevent suicide and substance-related deaths, uses program evaluation to help make programs better, and helps individuals recover and contribute in their communities. Thus, it's critically important that future Federal grants to require evidence-based programs and data-driven program improvements. It has been one of the great joys of my life to watch our SAMHSA grant programs help individuals who previously did not want to live, re-build a life based on their values, talents, and strengths, often overcoming psychosocial barriers and past trauma to do so. In the words of one of our clients: "There's no way to define a future if you are not there for it. And everyone is really focused on making sure that you stay there for it, stay alive, stay safe. It's been

really helpful for me to develop my own path, and feel supported, but feel directed in ways that need to be. It's made a lot of difference."

Thank you, and I look forward to your questions.

I would like to thank Chair Murray and Ranking Member Burr and this Committee for your dedication to seeking solutions to the growing mental health and substance use crisis our country is facing today. I'd also like to thank Senator Braun for his leadership for the State of Indiana, which is one of the states we are proud to serve in. I'm honored to be here as the voice of my colleagues at Centerstone and most importantly on behalf of the people we serve.

At Centerstone's Research Institute (CRI), we conduct research to prevent and cure mental illness and addiction. We also work to translate research into meaningful clinical practices and implement research-based strategies in real-world settings, thereby reducing the research-to-practice gap. CRI's workforce is interdisciplinary and comprised of Physicians, Psychologists, Dissemination and Implementation Scientists, Counselor Educators, Program Evaluators, Social Workers, Public Health Advisors, Biostatisticians, Clinical Transformation Specialists, Design Thinking Experts, and others. Centerstone's Research Institute is a company of Centerstone, the nation's largest nonprofit mental health company who provides community-based behavioral health care, substance-abuse treatment and intellectual and developmental disabilities services in Florida, Illinois, Indiana, and Tennessee.

We applaud this hearing today because unfortunately, our rates of deaths of despair are rising. Deaths of despair are deaths by suicide, overdose, and disease due to excessive drug or alcohol use. Over the last 10 years, deaths of despair have increased nearly twofold to over 185,000 deaths in 2020 (CDC, 2022). Deaths of despair have increased so drastically that they have substantially impacted our life expectancy in the United States in 2015, marking the first decrease in life expectancy in decades; all of this occurring BEFORE the pandemic.

Today, mental health and addiction services are needed now more than ever as the COVID–19 pandemic has increased the prevalence and incidence of behavioral health disorders in adults and children/adolescents. Nationwide, 2020 was the deadliest year on record for fatal overdoses.[1] Within the pediatric population—children's emergency room visits related to mental health spiked dramatically—up 24 percent for kids 5 to 11 years old and 31 percent for teenagers 12 to 17 years old.[2] Even before the pandemic, 75 percent of U.S. counties experienced severe shortages of mental health providers.[3] As demand for behavioral health services continues to rise, and workforce challenges increase, providers around the Nation are struggling to meet the demand.

As one of the nation's leading not-for-profit providers of behavioral health—we are acutely aware that mental health and substance use disorder challenges are a growing concern within our communities. We see it with our teachers, healthcare workers, our firefighters and police, our returning military service personnel, and our own families. To this end, in addition to our oral testimony, we offer several policy recommendations to address the nation's growing behavioral health needs that we believe are realistic, bipartisan, and aligned with the best science of care.

I. Advancing the best science of care relative to suicide prevention and intervention; particularly as the Nation prepares to launch 9-8-8 in July of '22

In 2020, nearly 46,000 people died by suicide a slight decrease from the year before. However, this doesn't tell us the whole story. Deaths of despair have been rising dramatically in the US over the past decade. Deaths of despair is defined as all deaths by suicide, overdose, and disease due to excessive drug or alcohol use; it is a term often used because of their shared underlying factors and the difficulty to parse apart one death from the other (that is, suicides are often misclassified as overdoses). Over the last 10 years, deaths of despair have increased nearly twofold to over 185,000 deaths in 2020 (CDC, 2022). Deaths of despair have increased so drastically that they have substantially impacted our life expectancy in the United States in 2015, marking the first decrease in life expectancy in decades; all of this occurring BEFORE the pandemic (see table 1 and table 2).

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[1] *https://www.politico.com/news/2021/07/14/covid-pandemic-drug-overdoses–499613*

[2] *https://www.cdc.gov/mmwr/volumes/69/wr/mm6945a3.htm*

[3] Macher, D., Seidman, J., Gooding, M., & Diamond, C. (2020, May 11). COVID–19 is Stressing a Fractured Mental Healthcare System in the US. *https://avalere.com/insights/covid–19-is-stressing-a-fractured-mental-healthcare-system-in-the-us.*

Table 1

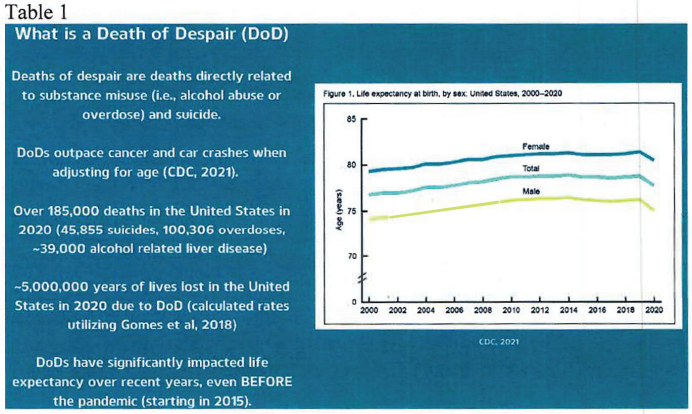
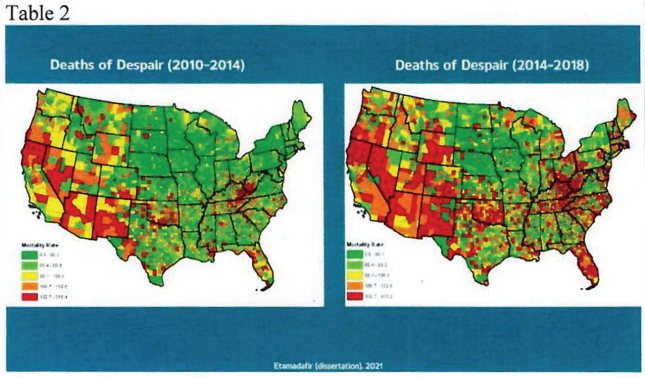


Table 2



In response to these alarming trends, Congress in partnership with the Substance Abuse and Mental Health Services Administration (SAMHSA) created the Zero Suicide Initiative and other grant programs aimed at suicide prevention. Indeed, research suggests that up to 90 percent of individuals at risk for suicide interact with healthcare systems within the year before there death, such that healthcare systems are an ideal place for suicide prevention and treatment (Ahmedani et al., 2019). Centerstone's healthcare system is honored to share our experience and the outcomes from some of the SAMHSA grants that we have received. I hope to illustrate that through national funding efforts, evidence-based practices, and data-driven program innovation, suicide deaths can be prevented.

Through our Zero Suicide SAMHSA grant, we are now using existing evidence-based practices known to decrease suicide throughout our health system, and using data to make them even better. For example, through our grant, we have updated our Zero Suicide Pathway to ensure everyone in our healthcare system gets evidence-based suicide screening, risk management, and treatment. Specific to suicide screening, we have realized through Centerstone data surveillance that the Columbia Suicide Severity Rating Scale (C-SSRS; Posner et al., 2011) works well at identifying many people who are suicidal and need care—but does not identify a group of individuals who may be most likely to die by suicide. For this reason, we have moved toward a new screening system that first asks about more "upstream" risk factors for suicide (such as thwarted belongingness, perceived burdensomeness, and acquired capability for suicide; Joiner et al., 2005), and then asks about suicide di-

rectly (PHQ–9; C-SSRS). In this way, we are building on the existing evidence to cast a "wider net," to potentially prevent and treat drivers of suicide risk earlier in the course of illness, and identify a unique cohort of individuals who may be at the highest risk for suicide who may not disclose if asked directly (Louzon et al., 2016: Richards et al., 2019).We were able to find this out due to data monitoring strategies enacted with Zero Suicide funding. As a result, we are able to apply lessons learned from this data by going upstream, testing new research ideas and asking different questions that target the DRIVERS of suicidal thinking (i.e., disconnection, burdensomeness) but not suicidal thinking directly.

Through our Zero Suicide SAMHSA grant, we have also piloted a suicide prevention specialty care clinic, the first known in Community Mental Health Centers in the United States. Whereas we expect all of our Centerstone clinicians to be able to identify suicide risk, manage risk at the appropriate level of care, and know at least one frontline evidence-based treatment for suicide, we realize it is difficult and costly to train all of our providers in multiple suicide-specific treatments and keep them up to date as fast as the science changes. In medicine, we have seen that people often get better outcomes at cost, when at high risk, by seeing a medical specialists (e.g., cardiologists, oncologists). It is possible, then, that the same may be true for suicide risk. Through our grant, we are creating a referral system to where persons at the highest risk can be seen by providers in our specialty clinic for their care. Our providers in this clinic have been well-trained in over six, modern, evidence-based, suicide-specific treatments and are well-equipped to manage high risk conditions and co-occurring diagnoses. Thus far we've had really great feedback and outcomes—both from the clinicians we've trained as well as the clients we're serving. As one of our clinicians stated recently: "My perspective on suicide prevention has changed significantly since I started being part of this clinic . . . I believe being part of this [specialty] clinic has helped me gain confidence in treating clients, reduced the fear in treating suicidal ideation/behavior, and start to have in-depth . . . conversations with clients about how to manage their crisis and explore steps toward a life worth living."

An additional area where we've applied our Zero Suicide funding is what is referred to as *"implementation science."* We know that a lot of treatments that are studied in the lab or university—as great as they are—once you put them in a real-world environment often times do not work in the way they were designed. This is because there are systems level barriers to where it may be harder to use those therapies or treatments in the ways that were studied. Implementation science helps us to truly understand how these approaches are implemented and how we can navigate workflow challenges and other community-level barriers to change our treatments so that they can be modified to truly work in real world practice settings.

We have also participated in several SAMHSA grants, such as the Garrett Lee Smith and National Strategy for Suicide Prevention Grants (GLS; NSSP) that have allowed us to provide suicide crisis follow-up services to adults and youth. Research suggests that individuals discharged from emergency departments and inpatient units are at high risk for suicide and often experience difficulty linking to outpatient care services (Chung et al., 2017). Our Crisis Follow-up Program provides phone calls to clients and a supportive phone app within the 4 weeks post-discharge. Our program uses an evidence-based framework (Joiner et al., 2005) to help adults and youth re-establish a sense of connectedness to others, re-discover and apply their talents and life values—such that they don't feel that they are a burden to others, monitor their suicide risk using a phone app, and successfully link to outpatient care. Data outcomes from our program suggest statically significant and clinically meaningful outcomes, including reductions in suicidal ideation, increases in self-efficacy to prevent suicide, and that between 70 percent to 90 percent successfully link to outpatient care (compared to the national average of 40 percent). It's critically important to note that, because adults and youth in this program are experiencing care transitions, these services provided to them would be unbillable, and impossible, without the Federal SAMHSA grants. Knowing this program works is especially timely given the July 2022 launch of "988" as the three-digit dialing code for the National Suicide Prevention Lifeline (NSPL).

As we look toward launching 988 we must also continue to evaluate strategies to ensure these data-supported services are funded and available nationally, this is why we also support the Behavioral Health Services Crisis Expansion Act (S. 1902) as a crucial component to financing a crisis care continuum. With appropriate funding and resources—we know we can prevent deaths and save lives. That's why this grant is so important. Additionally, we encourage Congress's consideration of longer term, more sustainable financing mechanisms.

As we look toward launching 988, we must continue to evaluate strategies to ensure these data-supported services are funded and available nationally. To that end, we recommend:

Passage of the Behavioral Health Services Crisis Expansion Act (S. 1902) as a crucial component to financing the crisis care continuum; and

That the final Conference Report for the fiscal year 2022 Labor-HHS Appropriations bill include:

10 percent set-aside for mental health crisis systems in the Mental Health Block Grant (MHBG) program;

$100 million to establish the Mental Health Crisis Response Partnership Pilot Program to help communities create mobile crisis response teams that divert the response for mental health crises from law enforcement to behavioral health teams; and

$375 million to provide grants to Certified Community Behavioral Health Clinics (CCBHCs) to provide treatment for those with mental health illness.

Ultimately, we believe that our nation's ability to respond to behavioral health crises in the same way we respond to other medical emergencies—with prompt, effective, and culturally competent care—is essential to our collective well-being. With the new three-digit crisis number becoming universally available in July 2022, it is essential to act quickly to fund and implement important components of the overall 988 system.

II. Addressing the behavioral health workforce shortage, while increasing care integration/access

There are other community behavioral health and substance use disorder grants that have also made a meaningful impact on the people we serve. For example, a program that has been a lifeline is the Certified Community Behavioral Health Clinic (CCBHCs) Medicaid demonstration and CCBHC SAMHSA grant program. Our CCBHC program also allowed us, when the COVID–19 Pandemic hit, to examine if our clients were getting good outcomes via tele-health and phone compared to face-to-face treatment. Our evidence indicated they were, which has increased our continued application of telehealth throughout our operations to ensure patient access and outcomes.

On the whole, Certified Community Behavioral Health Clinics (CCBHCs) can play a transformative role in addressing historically dire workforce shortages, creating a more seamless/integrated care delivery system, and bolstering the nation's 988 preparedness; all while ensuring providers meet quality metrics. Specifically, these entities are designed to provide a comprehensive range of mental health and substance use disorder services to vulnerable individuals in a single location. CCBHCs are responsible for providing nine types of services, implementing evidence-based practices, coordinating care, and integrating with physical healthcare services. To date, there are two types of this model—the grantees, which are in the pilot phase, and CCBHC Medicaid demonstrationsites which have permanently expanded the model and adopted a new payment methodologies, more akin to the FQHCs, to support on-going services.

Nationally, the CCBHC model has generated the following outcomes.

*Indiana Outcomes (*Pilot/Grantee Phase)*

The CCBHC model in Indiana has helped ensure positive outcomes among Centerstone clients, including:

73 percent of adult clients reported little/no depressed feelings

93 percent reduction of clients hospitalized for mental health reasons in previous 30 days

100 percent reduction of clients who utilized an emergency room for behavioral health issues in previous 30 days

64 percent increase in adult clients reporting their symptoms were not bothering them

*Illinois Outcomes (*Pilot/Grantee Phase)*

The CCBHC model in Illinois has helped ensure positive outcomes among Centerstone clients, including:

50 percent decrease in homelessness

60 percent reduction of clients who utilized an emergency room for behavioral health

50 percent decrease in nights spent in jail

New York

New York officials reported that CCBHCs had a 54 percent decrease in the number of individuals using inpatient behavioral health services, which translated to a 27 percent decrease in associated monthly costs.

Texas

The CCBHC model in Texas is projected to save $10 billion by 2030;

In 2 years, there were no wait lists at any CCBHC clinic; and

40 percent of clients treated for co-occurring SUD and SMI needs, compared to 25 percent of other clinics

Missouri

Overall access to mental health and addiction treatment services increased 23 percent in 3 years, with veteran services increasing 19 percent; and

Missouri found a 76 percent reduction emergency room visits and hospitalizations where CCBHCs were embedded in those facilities. In those same CCBHC areas, Missouri law enforcement saw a 55 percent decrease in interactions with people with behavioral health conditions.

Additionally, data from providers across the Nation has found that the CCBHC model significantly addresses workforce challenges. [4]

Specifically, the payment methodology associated with CCBHCs allows providers to reimburse for services they may not have a direct reimbursement for—i.e., assistance with addressing social determinants of health, robust care coordination, crisis services, and covering positions (i.e., peer support specialists) that may not be recognized by all payer types, etc. Many of these non-billable services and provider types are critical in providing coordinated care that results in increased patient outcomes as well as a financial model that supports the existing workforce.

It's estimated that as of January 2021 CCBHCs added 9,000 new positions nationwide; and

On average, this resulted in 41 new jobs per clinic.

Given the growing need for improved access, bolstered workforce, and assurances that consumers received evidenced based treatments; **we support the passage of The Excellence in Mental Health and Addiction Treatment Act of 2021—S. 2069** led by Senators Stabenow (D-MI) and Blunt (R-MO) which would allow every State the option of joining the innovative Certified Community Behavioral Health Clinic (CCBHC) Medicaid demonstration and authorize grant (pilot) investments in the model for current and prospective CCBHCs.

II. Expanding access to telehealth services for behavioral health care

While we applaud inclusion of the telemental health services provision in the December 2020 end of year COVID relief package (Consolidated Appropriations Act of 2021, Section 123), we believe putting service restrictions on telehealth access for mental health services through in-person requirements undercuts the very tenets around the flexibility and access afforded by telehealth and other virtual care modalities. For example, under this new rule a beneficiary who—during the PHE was seeing a provider several hours from their home via telehealth—will have to now see their provider in-person, at least one time per year, to maintain continuity of care after the pandemic. This will most certainly delay or fully eliminate access to care for some consumers. Furthermore, the new requirement for an in-person visit applies only to mental health treatment, whereas Medicare beneficiaries seeking treatment for substance use disorder (SUD) via telehealth are not subject to this requirement. Given the elevated occurrence of SUD with mental health comorbidities, and recent reports indicating that 2020 was the deadliest year for overdoses, [5] this requirement ultimately creates new barriers which could result in significant delays in access to lifesaving care. Last, this requirement will further encumber already overworked providers to arbitrarily delineate between their patients on "who gets what type of service" based on diagnosis, rather than clinical presentation and best practice. This approach is counter to the gold standard of providing

[4] *https://www.thenationalcouncil.org/wp-content/uploads/2021/05/052421—CCBHC—ImpactReport—2021—Final.pdf—daf—375ateTbd56 (p. 7)*

[5] *https://www.politico.com/news/2021/07/14/covid-pandemic-drug-overdoses–499613*

the "right care at the right time" to improve patient and population health outcomes.

With regard to program integrity—telehealth, by design, is a transparent and accountable means of care delivery. Technology platforms that provide telehealth are currently capable of capturing a range of data points from telehealth and telephonic encounters that can offer transparency to the delivery of virtual care and protect against fraudulent actors. Unlike in-person care, telehealth encounters conducted over platforms such as Electronic Health Records (EHRs) or other tech-enabled landscapes that automatically capture the time call took place, duration, patient information, and other details that can be used to strengthen compliance efforts. As long as the provider is utilizing a technology platform that records relevant data, it does this for every connection—making the engagements recordable, auditable, and actionable.

In order to address this telemental health access gap, we recommend passage of The Telemental Health Care Access Act—S. 2061 led by Senators. Smith (D-MN), Cassidy (R-LA), Cardin (D-MD), and Thune (R-SD). The Telemental Health Care Access Act would provide continuity in behavioral health care access by removing the statutory requirement that Medicare beneficiaries be seen in person within 6 months of being treated for a mental health service via telehealth.

In summary, Federal funding works. Through these grants, our clients are establishing safer, better lives they are wanting to live, and we couldn't provide this treatment without these grants. We need to continue to ensure that SAMHSA grants require the implementation of evidenced-based services, so we can test these models and iterate based on lessons learned. Additionally, we need to look toward nation-wide, sustainable means of funding for areas where the data has indicated need and benefit to consumers. Broadening insurance and telehealth coverage for the full continuum of behavioral health services—and, in particular, crisis care—as well as advancing CCBHCs can play a transformative role in meaningfully addressing our nation's growing behavioral health crisis.

Thank you for your continued focus on this important matter, if there are any additional questions and/or data we might be able to provide—please do not hesitate to reach out by contacting either myself or Lauren Conaboy, VP of National Policy, Centerstone at *lauren.conaboy@centerstone.org*.

[SUMMARY STATEMENT OF JENNIFER LOCKMAN]

As of 2020, suicide was the 12th leading cause of death in the United States for adults, and the 3d leading cause of death for youth. For every suicide death, there are approximately 1.1 million suicide attempts, or about one every 27.5 seconds (Drapeau & McIntosh, 2021).

For this reason, Congress in partnership with the Substance Abuse and Mental Health Services Administration (SAMHSA) created the Garrett Lee Smith, National Strategies for Suicide Prevention, Zero Suicide, and Covid–19 Emergency Response suicide prevention grants.

Through our Zero Suicide SAMHSA grant, we have updated our Suicide Prevention Pathway to ensure everyone in our healthcare system gets evidence-based suicide screening, risk management, and treatment. We have moved toward a new screening system that first asks about more "upstream" risk factors for suicide (such as thwarted belongingness, perceived burdensomeness, and acquired capability for suicide; Joiner et al., 2005), and then asks about suicide directly (PHQ–9; C-SSRS).

We have also piloted a suicide prevention specialty care clinic, the first known in Community Mental Health Centers in the United States. Through our grant, we are creating a referral system so that persons at the highest risk for suicide can be seen by providers who are trained in multiple suicide-specific treatments—the best that science has to offer.

Our grants have also provided a Crisis follow-up program to youth and adults during care transitions from inpatient facilities, a high-risk period for suicide attempts and re-attempts (Chung et al., 2017). Our data suggest this program helps individuals re-establish connectedness, decrease their sense of burdensomeness, reduce suicidal ideation, and successfully link to outpatient care (70–90 percent of the time).

These services would be unbillable, and impossible, without the Federal SAMHSA grants. Knowing this program works to save lives is especially timely given the July

2022 launch of "988" as the three-digit dialing code for the National Suicide Prevention Lifeline (NSPL).

Another grant program that has been a lifeline is the Certified Community Behavioral Health Clinic (CCBHCs) Medicaid demonstration and CCBHC SAMHSA grant program, which allow consistent care for those with mental health or substance use conditions and a place to go in times of crisis.

Centerstone is pleased to be one of only a few Comprehensive Opioid Recovery Center grant recipients in the Nation. We administer this grant in Indiana, where we were able to train over 467 professionals in evidence-based practices and open a recovery house for women.

All the things you might take away from my testimony today please be sure to hear this: Federal funding works. Federal funding helps prevent suicide and substance-related deaths, uses program evaluation to help make programs better, and helps individuals recover and contribute in their communities. We need to continue to ensure that SAMHSA grants require the implementation of evidenced-based services, so we can test these models and iterate based on lessons learned. Additionally, we need to look toward nation-wide, sustainable means of funding for areas where the data has indicated need and benefit to consumers.

The CHAIR. Thank you very much.

Ms. Rhyneer, we will turn to you.

STATEMENT OF CLAIRE RHYNEER, MENTAL HEALTH YOUTH ADVOCATE, ANCHORAGE, AK

Ms. RHYNEER. Chair Murray, Ranking Member Burr, Senator Murkowski, and Members of the Committee, thank you for having me here to testify today. My name is Claire Rhyneer, and I am from Eagle River, Alaska. In high school, I was a storyteller and facilitator for mental health advocacy through storytelling.

This organization is a youth led, youth founded group of Anchorage students working to decrease stigma and increase access to mental health resources. Last year, I worked as a program and outreach coordinator for NAMI Anchorage, the Alaska affiliate for the National Alliance on Mental Illness.

I am here today to advocate for youth who have or currently are experiencing mental health conditions. I am advocating for myself, for my peers, for Alaskan youth, but also for youth across the Nation to give them a voice. To be completely clear, the people who most need the services are least able to be here advocating. I am representing the tip of the iceberg.

A few years ago, I experienced a difficult and dark period of depression. But more than being difficult and dark, my experience was governed by confusion. I was self-harming and all I felt was uncertainty. I asked myself, do I need help? How should I know? I turned to Google, taking dozens of are you depressed quizzes. However, Google is not a doctor and is in no position to diagnose a middle school girl or anyone. It left me more confused. Each night, I wondered what was wrong, and in hindsight, it is terrifying to know that I was physically harming myself and still unsure if I needed support. What I uncovered online and on social media was horrifying.

The photos, videos, and stories were disturbing, but it was even more disturbing to discover that I was attracted to it and found myself going back to it. No one bullied me or neglected me. From an external perspective, my life was perfect. But mental health was never discussed at school, at home, or even in my health classes

beyond the, take care of yourself, get sleep, eat well, and exercise spiel.

I kept telling myself everything was okay, Why should I feel sad? Why should I feel lost? I am so fortunate. How could I possibly feel this way? Ultimately, I didn't seek help because I didn't know if anything was wrong. And I am more than an anecdote. When I tell a roomful of people that I was confused or that I turned to Google for help, I see a course of nods.

I need more than one hand to count the number of close friends who have experienced suicidal ideation. And barriers to care do not discriminate. They infiltrate every home, regardless of ethnicity, class, or geography. Compared to most, I am privileged. Finding a community of peers let me know that I was not alone. I was once again able to be focused on school, sports, my family and friends. I learned how to maintain my wellness. And I am proud to be able to say, I know where you are coming from, and this pain can be temporary and to know that it is true.

The people who did not find these supports, unlike me, are not here. Many of them will never be able to tell us their story. So we have an obligation to these youth to make a difference. We need to support school counselors, station social workers in schools, fund wellness programs at universities, and introduce mental health curriculum into health classes where they belong.

We must reflect on the way we separate academic success from mental well-being. We need to make care more affordable, and insurers incorporated into primary care and that it is covered by insurance. We need culturally competent health care workers and diversity among providers. We need to reduce stigma, promote early intervention, normalize mental health conversations early, and educate our youth, teachers, and parents.

Those of us who know suicide and mental illness are preventable are watching the leaders of this country and waiting for you to do something. And the ones who think suicide and suffering is inevitable, they need you. Vulnerability is contagious and powerful.

I am here in the hopes that my story might inspire change, both for all of us to work toward healthier communities, but also to inspire other young people who may be listening. If you are suffering, I urge you to speak up. Thank you.

[The prepared statement of Ms. Rhyneer follows:]

PREPARED STATEMENT OF CLAIRE RHYNEER

Chair Murray, Ranking Member Burr, Senator Murkowski, and Members of the Committee: Thank you for having me here today to speak from the perspective of a young person who understands the importance of mental health awareness.

My name is Claire Rhyneer, and I am from Eagle River, Alaska. In high school I was a storyteller and facilitator for MHATS (Mental Health Advocacy through Storytelling). MHATS is a youth-led, youth-founded group of Anchorage students working to decrease stigma and increase access to mental health resources through true, personal, short stories of mental health struggle and triumph. Last year, following my work with MHATS, I worked as Program and Outreach Coordinator for NAMI Anchorage, the Alaskan affiliate for the National Alliance on Mental Illness.

I'm here today to advocate for youth who have, or currently are experiencing mental health conditions. I'm advocating for myself, for my peers, for Alaskan youth, but also for youth across the Nation to give them a voice.

To be completely clear, the people who most need the services are least able to be here advocating. I am representing the tip of the iceberg.

A few years ago, I experienced a difficult and dark period of depression. But more than being "difficult" and "dark" my experience was governed by confusion. I was self-harming and all I felt was uncertainty. I asked myself: Do I need help? How should I know? I turned to Google, taking dozens of "Are You Depressed?" quizzes.

However, Google is not a doctor and is in no position to diagnose a middle school girl—or anyone. It left me more confused. Each night I wondered not only what was wrong, but if something was wrong at all. In hindsight, it is terrifying to know that I was physically harming myself and still unsure if I needed support. No one bullied me or neglected me. From an external perspective, my life was perfect. I was getting good grades, my parents loved and cared for me, and I had friends I could talk to. But mental health was never discussed at school, at home, or even in my health classes, besides the "take care of yourself, get sleep, eat well, and exercise" spiel.

In the absence of relevant information, I turned to online communities. What I uncovered on social media was horrifying. I could find images, drawings, stories, even videos of intense self harm. It was disturbing to find, but it was even more disturbing to discover that I was attracted to it and found myself going back to it.

I still cannot look back at the journal entries from those years, but I know I wrote down "I don't know what is happening to me" over and over and over again. I kept telling myself everything was okay. *Why should I feel sad? Why should I feel lost? I'm so fortunate, how could I possibly feel this way? Maybe I'm making this all up in my head,* I thought.

Ultimately, I didn't seek help because I didn't know if anything was wrong. I didn't believe myself. It's like having a broken leg and telling yourself that you're just imagining the pain, it will go away on its own, and there's no bother in telling anyone because it's probably not a real problem. I told myself my self harm was just for attention.

I am more than an anecdote. When I tell a roomful of people that I was confused, or that I turned to Google for help, I see a chorus of nods. I can count on more than one hand the number of close friends who have experienced suicidal ideation. Starting in middle school, there were nights when I wasn't sure if I would see my friend the next day at school.

In suicide prevention, we emphasize that there is no one reason that someone dies by suicide. There are always a multitude of factors. Not only do college and university therapy offices have months-long waitlists, but private practitioners are cost-prohibitive and aren't covered by insurance. High school counselors are scarce and ill-equipped. Many youth never even reach the point of asking for help. They are like me. They doubt and diminish their experience. They don't believe anything is wrong. They're scared to reach out. They're worried about what their community will say. They think their family will crack jokes or not take them seriously. They expect their parents to blame themselves. They're afraid they'll be seen as "weak," "crazy," "attention-seeking," "wacko," "broken," or a "lost cause."

These barriers to care do not discriminate. They cross every border and infiltrate every home, regardless of race, class, or geography.

However, living in Alaska poses unique challenges. First, Alaska's dark winters make SAD (Seasonal Affective Disorder) more prevalent. In areas near the equator, only 1 percent of the population experiences SAD. In Alaska, that number is closer to 10 percent. Second, the generational trauma our Alaska Native populations suffer from colonization contribute to higher rates of substance use and mental health conditions. Third, the prevalence of guns in Alaska generate higher suicide rates. Alaska Native men between the ages of 15–24 have the highest rate of suicide among any demographic in the country. Fourth, providers are few and far between, especially in rural areas and small villages. Youth who need services must fly 2 hours away from their home, leaving behind their family and support systems. While telehealth has become more accessible, good weather, power, wifi, and service are not guaranteed. Fifth, the services Alaska does have are limited. They are overwhelmed, underfunded, and exhausted. While I worked at NAMI, I had to tell people they would be on a waitlist for 9–12 months before they'd receive care from a case worker. It would be 3 months before the patient would even be contacted to confirm they were accepted as a patient. It would be another 6 months after that before they could talk to a case worker and begin care. And last, transportation is especially onerous in Alaska, even in its central hub, Anchorage. People who signed up for NAMI recovery programs canceled after they realized it wasn't virtual. They couldn't afford transportation for the few miles between their home and our centrally located office building.

The Covid–19 pandemic exacerbated and introduced new issues. During typical high school classes, a teacher is one of the first lines of defense. They can catch changes in a student's behavior, performance, and attitude. But during zoom classes, I stared at a screen of gray squares. Questions from the teacher were met with silence. Teachers found fewer opportunities to ask, "Hey, are you okay?" "How are things going at home?" "You seem a little off, is there anything you want to talk about?" Furthermore, during the first year of online school, student support programs disappeared. Suicide prevention trainings and presentations were put on hold. General clubs moved online and lost attendance. Sport games and races barred spectators and family members. Students in unsafe families couldn't find the security they typically found at school.

Compared to most, I am privileged. In my Junior year, I was introduced to YANA (You Are Not Alone) Club, suicide prevention trainings, and MHATS. It was my own friends at MHATS who taught curriculum related to mental health and helped me tell my story. It's because of these resources and education that I opened up to my parents last year. I am now able to be focused on school, on sports, on my family and friends, and maintain my wellness. I am proud that I am now able to point my friends in the right direction when they express similar feelings. I am proud to be able to say "I know where you're coming from," or "I know how that feels." I am proud to be able to say "this pain can be temporary" and to know that it is true.

But this is only true because of the education and support I received. We need to support school counselors, station social workers in schools, fund wellness programs at universities, and introduce mental health curriculum into health classes where they belong. We must reflect on the way we separate academic success from mental well-being. We need to make care more affordable, ensure it's incorporated into primary care, and that it's covered by insurance. We need culturally competent health care workers and diversity among providers. We need to reduce stigma, promote early intervention, normalize mental health conversations early, and educate our youth, teachers, and parents.

We cannot be satisfied with allowing our children and youth to be educated by mental health through social media and searching online. We cannot be complicit in allowing my friends and classmates and your kids and neighbors to suffer in silence. We cannot knowingly let our students experience the confusion, doubt, and harm that I felt.

I am here because I am a privileged voice. The people who are failed by this system aren't here. They can't be. They are busy going to school, they are caring for their families, they are working multiple jobs. They are searching "Am I depressed?" on Google and are self harming in their bedroom. Their friends are filling in as therapists, sacrificing their own well-being to listen and support.

Those of us who know suicide and mental illness are preventable are watching the leaders of this country and waiting for you to do something. And the ones who think suicide and suffering is inevitable? They need you.

Thank you for inviting me to testify. I would not have been here without my peers at MHATS, the people at NAMI, my parents, and the friends and family who have been generous enough to share their stories with me and the rest of the world. Vulnerability is contagious and powerful. I'm here in the hopes that my story might inspire change—both for all of us to work toward a healthier community, but also to inspire other young people. If you are suffering, I urge you to speak up. Thank you.

[SUMMARY STATEMENT OF CLAIRE RHYNEER]

In high school, I was a storyteller and facilitator for MHATS (Mental Health Advocacy through Storytelling). MHATS is a youth-led, youth founded group of Anchorage students working to decrease stigma and increase access to mental health resources through true, personal, short stories of mental health struggle and triumph.

Last year, following my work with MHATS, I worked as Program and Outreach Coordinator for the Alaskan affiliate of the National Alliance on Mental Illness (NAMI) in Anchorage.

I am here today to advocate for youth who have or currently are experiencing mental health conditions. I am advocating for myself, for my peers, for Alaskan youth, but also for youth across the Nation to give them a voice.

Mental health was never discussed at school, at home, or even in my health classes, besides the "take care of yourself, get sleep, eat well, and exercise".

I didn't seek help when I was experiencing mental health issues, because I didn't know if anything was wrong. I did not believe myself. I told myself my self harm was just for attention.

The Covid–19 pandemic exacerbated and introduced new issues. During online school, teachers found fewer opportunities to ask, "Hey, are you okay?" "How are things going at home?" "You seem a little off, is there anything you want to talk about?"

At school, I was introduced to YANA (You Are Not Alone) Club, suicide prevention trainings, and MHATS. It is because of these resources and education that I opened up to my parents last year.

I am now able to focus on school, on sports, on my family and friends. I learned how to maintain my wellness.

We need to support school counselors, trained social workers in schools, fund wellness programs at universities, and introduce mental health curriculum into health classes where they belong. We must reflect on the way we separate academic excellence, success and mental well-being. We need to make care more affordable, ensure it's incorporated into primary care, and that it is covered by insurance.

We need culturally competent health care workers and diversity among providers. We need to reduce stigma, promote early intervention, normalize mental health conversations early, and educate our youth, teachers, and parents.

The CHAIR. Thank you very much. I want to thank all of our witnesses, but Ms. Rhyneer, thank you so much for your very compelling personal story, your courage, and you are making a difference. We all appreciate it. With that, we are going to begin a round of 5 minute questions. I again ask my colleagues to keep track of the clock and stay within those 5 minutes.

I will begin with Dr. Prinstein. And as we all know, the last 2 years have been incredibly difficult in so many ways, but especially on children and youth. They have faced huge disruptions in their own lives. They have lost loved ones, including their parents. They have missed out on valuable time with their friends and teachers.

It has become so dire that some of our leading experts have declared a "national emergency" when it comes to child and adolescent mental health. You know, as a mother, myself, a grandmother, and as a former preschool teacher, I am really worried about our kids right now. And we just heard very compelling story from one of them. I know parents from my home State of Washington all the way to here to the Capitol are really concerned about this.

I think it is really important to address the effects of trauma, substance use, grief, and other stressors on our kids. And I wanted to ask you today to talk with us about the best practices for identifying trauma and other stressors among our children.

Mr. PRINSTEIN. Thank you. We have a number of assessment tools that we can use to screen kids and to understand what their experiences may be or even before they experience a crisis. We need the support to be able to launch those tools and also to do research to examine how we can use technology to really make the most use of the kinds of passive screening or opportunities to intervene and offer mental health tips, anything that we can do.

In particular, this is really important when we think about underserved and underrepresented youth. It is absolutely critical that we are discussing mental health in schools that we are building into our curriculum social emotional competence.

We have the tools to build kids' resilience. We just need the opportunity to be able to teach what we know to all of those teachers and counselors and administrators so we can help them to identify kids before they reach a moment of trauma.

The CHAIR. Thank you. Dr. Durham, Dr. Goldsby, I want to talk about inequality within our health care system. It has really led to disparities in our health care access and outcomes and resources, and behavioral health is obviously no exception. When trying to get care, people of color often face systemic barriers and are less likely to complete treatment or even get appropriate services. Individuals with disabilities are five times more likely to have mental health needs, often can't find providers to get the care they need.

Meanwhile, in our rural communities, we face significant provider shortages, and members of the LGBT community are more likely to experience mental health and substance use disorders. So as this Committee now considers legislation to improve mental health and substance use disorder outcomes, we have to do everything we can to address those disparities.

Dr. Durham, I wanted to start with you. Your work is at a safety net hospital, and you see parents experiencing—patients experiencing mental health and substance use crisis. What barriers to care do your patients experience and how do they impact behavioral health outcomes and access?

Dr. DURHAM. Thank you, Senator Murray, for that question. You described a lot of things in your opening statement that are inequitable in substance use and mental health treatment in general. I think largely what many of us, as witnesses have said during our testimony so far, is that there is a huge inequity in just the workforce issue. Having mental health providers that maybe don't want to work with people with substance use issues, having folks with—that focus on substance use issues that don't want to work with the mental health aspect of the patient.

I think that adds a complexity when people want to go for care that they have to go to many different providers to get the treatment that they need. We need to stop siloing in health care in general and in the mental health care. This distinction that our physical health is separated from our mental health.

We see often that people get lost because they go from one provider to another trying to get the treatment they need and deserve, and they can't find one provider to do all of those things. The second thing I would say is that just in general, getting access to care is very hard for our patients. There are a lot of barriers when we start thinking about what substance use treatment programs only want to give medication versus thinking about other psychotherapeutic interventions.

How people get into treatment is very difficult sometimes. Unfortunately, providers will say, well, you need to go to the emergency room intoxicated to get a detox bed. If not, they are not going to accept you.

This is the reality of how patients get treatment in the system because of bed availability, because of the way reimbursement happens, because of the way insurers operate. And last but not least,

I do want to think about how do we think about substance use in general, the inequity in that.

I think it is probably the only disorder that we consider a crime. You can get stopped, you can get pulled over for simply using or possessing this, and we don't treat it like other mental health or physical health issues. I do believe it is a brain illness. It is chronic. It is relapsing and remitting. And it deserves the full treatment like anybody with diabetes, hypertension, or any other condition.

The CHAIR. Thank you. And I am out of time with Goldsby. I am going to come back to you, if I can, later on to ask you that question. And I will turn it over to Senator Murkowski.

Senator MURKOWSKI. Thank you, Madam Chair. Claire, thank you. Thank you for your testimony. Very, very compelling and thank you for your voice, your leadership in this very important area.

I recall a visit that I made out to rural Alaska some years ago. It was a town hall meeting with Native leaders and young people from neighboring village had come to the town hall and asked to be recognized, and they raised the issue of suicide. None of the adults in the room wanted to talk about it.

The young people, one young man said suicide is becoming normal within our village as far as the youth were concerned, which was shocking and troubling. But it was almost as if there was a generational disconnect. The kids wanted to speak about it, needed to speak about it, and the elders in the room were afraid. They were afraid, I believe, that if they spoke about it, it might be encouraged.

You have been involved in suicide prevention trainings in school, peer to peer. Share with me a little bit, if you will, and the Committee, not only the importance of increasing access to these trainings and the recommendations for how we can reach out to kids, because again, it is younger—it seems younger and younger children are feeling these sense of depression and despair and crisis and suicidal ideation.

It is important how we speak to one another so that it is heard. Can you address how we can provide for more in the curriculum that is actually meaningful to kids? How can we provide for counselors who understand how to speak the language? Because I fear that there is a disconnect there.

Ms. RHYNEER. Absolutely. Thank you. Yes, suicide is a huge issue in Alaska and actually one thing Alaska does the CUBS Behavior Survey, and they show that the percentage of students attempting suicide has grown significantly in the past few years. So in 2019, 25 percent of all students in the school district seriously considered suicide and 20 percent of them attempted—20 percent of them attempted it, and so that is one-fifth of my classmates. But like, how many parents do you think knew about it? Do you think one-fifth of parents really knew that their student had seriously attempted suicide?

One thing that prevents students from talking about it is honestly the stigma that parents have. So they never even reach the point of asking me out or asking for help because they doubt and

diminish their experience. They don't believe anything is wrong. They are scared. They think their family will crack jokes or not take them seriously, or they expect their parents to blame themselves.

They are afraid they will be seen as weak or crazy or attention seeking wacko, broken, a lost cause, any of those things. So reducing stigma in general, one of those things that we can do. Like in Alaska, what we are trying to do is pass a bill that would help bring mental health education into K–12 schools. So by talking about mental health in schools, specifically in health classes, we begin conversations early and allow space for people to share.

Health classes currently cover topics like nutrition and physical health, exercise, dental health, all these sorts of things, cancer prevention, and so mental health deserves to be a topic in one of those classes. It is just as important. And guidelines for this kind of curriculum would be developed with local and statewide and national agencies to make sure we are safe and age appropriate.

Of course, we wouldn't be teaching the same thing to high schoolers as elementary school kids, but it would help see symptoms and recognize them, and then what to do about them and reach out for help. So that is one really important thing.

Also, in terms of suicide prevention, just like clubs like you are not alone club, that those suicide prevention trainings in schools and goes around to classes and talks about it. That is a really important thing, too. So all of those things working together.

Senator MURKOWSKI. Thank you, Claire. Madam Chair, I am almost out of time, but I think every one of the witnesses in one way or another has talked about the need for workforce, and whether it is school counselors, those that can work with kids in programs, or whether it is all the way to the other end with a full psychiatric care that is available.

My hope is, is that we build out a package of focus on mental health. We really key in on the workforce issues because I think we recognize that in all our States, we are sorely, sorely lacking.

The CHAIR. Thank you very much. I look forward to working with you on that. Senator Casey.

Senator CASEY. Chair Murray, thank you for the hearing. And I want to thank you and Senator Murkowski and Ranking Member Burr, and of course our witnesses. I want to start with Director Goldsby with a question regarding plans of safe care.

This is an issue I have worked on for years to support both infants and families affected by substance use disorder. We know that infants and their parents need what I think most would refer to as non-punitive services, as well as treatment and support as parents navigate both recovery and parenting a young child. But despite longstanding Federal law, plans of safe care remain very much underutilized.

I appreciate the work of this Committee in the CAPTA legislation and authorization over time to address some of the issues that have contributed to these plans of safe care being underutilized.

Too many families are slipping through the cracks, and so in particular, I appreciate the effort to establish a reporting mechanism

when an infant needs a plan of safe care that is separate from the child welfare system.

But Director Goldsby, I would ask you, what steps can we take in Congress, especially here in the Senate, to help States and communities adopt public health driven approaches to substance use in both pregnancy and as well as to reach more families in need of support?

Ms. GOLDSBY. Senator Casey, I am glad you asked. You know, I think thanks to the work of this Committee and CAPTA work that we have underway. We are currently engaged in some in-depth technical assistance with my agency and our South Carolina social services agency as we work hand in hand to develop a plan to address your exact concern.

Our Plan of Safe Care Workgroup is focusing on moving intervention services upstream, a more public health approach to support all pregnant individuals who might or may or may not have a substance use issue. But the screening earlier, having that universal screening brief intervention and referral to treatment for everyone earlier in pregnancy and often in pregnancy really minimizes additional prenatal substance exposure.

We have decided to call our plan of safe care a family wellness support plan because our aim will really be to initiate that prenatal plan sooner and as soon as the mother is identified, either with toxicology or the screening, so that we are offering a non-punitive, supportive set of services across our systems to include mental health and substance use treatment and all the wraparound services.

For some who have severe substance use diagnosis, this plan might include a referral to one of our family care centers, which is our residential treatment centers for women and children that are supported by the Substance Abuse Prevention and Treatment Block Grant, so that mothers can really stay engaged in services and supported through the delivery of their child. And that way, health care providers know that they are engaged, know that they are in treatment.

This is all going to lead to more likely results of family remaining unified at the time of delivery so that the mother and the children can continue on in that residential treatment or be discharged home to community based services.

But a lot of education has to be done among our health care community for them to understand that, like we mentioned, substance use disorders is not a moral failing, but is a health care issue, a disease State, and that people with mental health and substance use issues really shouldn't be further stigmatized but assisted.

I will just note that all of this work is supported by our Pregnant and Parenting Women program through SAMHSA, our expert work supported by SAMHSA discretionary grants and, of course, our Block grant.

Senator CASEY. Director, thank you for your work, and I appreciate your answer. I wanted to turn to Dr. Prinstein. On page 16 in your testimony, you note that implementation of integrated care,

where primary care and behavioral health care providers work as a team, remains unfortunately limited.

While there are a lot of models that integrate physical and mental health care, many physicians still don't have the ability to seamlessly connect patients to a mental health provider.

You mentioned some of the barriers, whether it is physical space or IT issues or clinical staffing. What should we do in terms of our focus to help more primary care providers move toward integrated care, and how can telehealth support the shift?

Mr. PRINSTEIN. Thank you. Integrated care is, in fact, an excellent way to go. As we just heard before, it is very hard for people to find a health care provider and a mental health care provider. And due to stigma, sometimes even pursuing that in person is difficult.

But walking into your physician's office is not attached to stigma. Three things to remember with integrated care. One, it is a lot more than just sticking to mental health care provider into the office of a physician.

This is really about the time and the funding that is required for cross training so that way physicians and mental health care providers can speak different language—each other's language, share records, share billing processes. These are usually not the traditional 1 hour sessions with the mental health care provider, so new billing processes are needed.

Two, substantial infrastructure costs are required to successfully integrate the integrated behavioral care, to implement that. So it is important to incentivize physicians to do so. And finally, a one size fits all approach is just not going to work with integrated behavioral care.

We have evidence that all approaches can be very effective, and primary care providers needs to be the folks to decide how best to set it up in a way that meets their needs, their patients, and their community.

Senator CASEY. Thank you, Doctor. Thank you, Chair Murray.

The CHAIR. Thank you.

Senator Collins.

Senator COLLINS. Thank you, Madam Chair. Dr. Prinstein, I want to discuss with you the impact that the prolonged COVID pandemic has had on our children's mental health. I was struck by two recent columns and the New York Times, written by David Leonhard, in which he makes the point very well. He writes, "the pandemic's disruptions have led to loss learning, social isolation, and widespread mental health problems for children.

Many American children are in crisis"—and here is the important point—"as the results of pandemic restrictions rather than the virus itself." We know, as Senator Murray has mentioned, that three medical groups representing pediatrics, child psychiatrists, and children's hospitals have recently declared a national emergency in child and adolescent mental health.

The New York Times columnist has concluded that remote schooling has failed and that there is little evidence that shutting schools leads to fewer COVID cases among children.

Given that the pandemic has persisted for 2 years, which is a good portion of many children's lives, what should we be doing as policymakers to balance pandemic response policies with the serious concerns that many parents have expressed to me about their children's—the impact on their children's mental health, the social isolation, the remote learning, the restricted activities that they are seeing directly are harming their children's social and mental development?

Mr. PRINSTEIN. Thank you for raising that, Senator Collins. APA joined with HIA and AAP in declaring that national emergency, and we agree. The science is telling us that kids are experiencing mental health difficulties for a whole host of reasons. One is, of course, the major stressor that has occurred in their lives. They are watching relatives that are passing away or being so ill that they need to go to the hospital. They have tremendous disruption of their roles and routines.

They see polarization in leaders with disagreements between parents and schoolteachers on what it is that they are supposed to do. And they are having a very difficult time also with social isolation, but not necessarily because of the isolation per se, but because of the time that kids are spending on social media instead, which we now know has incredibly dangerous effects not only on kids development but on the development of kids' brains during that time.

This is a very big issue and very concerning. It also is an opportunity. This is a time when we have people talking about mental health like they have never talked about before, and people are recognizing the need for us to be addressing mental health before it reaches the acute crisis, excuse me, of people needing to go and get outpatient or inpatient treatment.

This is an opportunity for us to really build into the fabric of how we educate, how we talk within our communities, the importance of mental health and resilience programs. Our entire mental health system right now is built for adults. It is built also for people who are already at the point in a crisis and need treatment. That is not what the science suggests. What we could be doing now and what this presents us with an opportunity to do is to pay attention to all of those folks who are at risk or who have not even shown any psychological symptoms yet and build the resilience necessary to ensure that they will never need outpatient or inpatient treatment.

That is what we are seeing with kids right now. There is a wide openness to talking about these issues, and kids, just as Ms. Rhyneer was talking about so eloquently, want us to step up and teach them information about mental health so they can learn the skills before they reach a crisis point.

Senator COLLINS. Thank you. Dr. Goldsby, my time is almost expired, but an estimated 636 people in Maine died from drug overdoses last year. That is a terrible and alarming record high.

But what it obscures is the actual number of overdoses which was in the neighborhood of 8,000 overdoses in the State of Maine,

where thanks to the heroic efforts of first responders, medical professionals, and sometimes bystanders, they were saved.

How can we ensure that non-fatal overdose patients are not just a statistic, but receive the care that they need to prevent a subsequent and potentially fatal overdose?

Ms. GOLDSBY. Senator Collins, we talk about overdose reversal in South Carolina as an intervention. And it is in that moment when somebody has faced a life threatening situation that they may be best reached by someone who offers them hope, hope to live, hope to a path to recovery, and I think those intervention services are key as we do more outreach, as we have our first responders saving lives, taking advantage of this critical crisis moment to engage people in services that will lead them on a path to long term recovery.

That can look at a number of ways with a number of different programs, but I think it is taking advantage of that moment, that lifesaving moment that we really engage in treatment services.

Senator COLLINS. Thank you.

The CHAIR. Thank you.

Senator Baldwin.

Senator BALDWIN. Thank you, Madam Chair. In 2019, I introduced the bipartisan National Suicide Hotline Designation Act, which was signed into law in 2020. Converting from the existing 10 digit number to 9–8–8 will make it easier for Americans to get the help they need, and I am proud of the investments included in the American Rescue Plan to support this transition.

Dr. Lockman, as you know, the 988 dialing code will be available nationally for calls, texts, or chat beginning in July 2022. What else should we be doing in Congress right now to make sure that the lifeline is equipped to facilitate real access to care? And how can we make sure that the lifeline reaches those in greatest need, including our LGBTQ youth?

Ms. LOCKMAN. Thank you so much for that question and thank you for your support. As you know, the advent of 988 opens up a whole new opportunity for people to have ready access to mental health care providers and paraprofessionals in ways that they haven't before. There is a couple of things that I think of in terms of what we can do to make sure that we are prepared for this transition.

The first one is to make sure that everyone has access on the crisis hotline to the very best in training. We know that the science advances so fast and there needs to be continued training and retraining to make sure we are using the very best practices to take care of people. For example, we rarely use language such as committed suicide anymore because it denotes that it is a crime. Instead, we say, died by suicide, and that is important for someone to know.

We also talk about things such as it is important to not die, not just for the sake of not dying, but for the sake of having time to transition to recovering the life that you really want to live. So one thing is making sure that there is continued investment and support and making sure that every single person, whether you are the person that they call or that they text, is ready and equipped

to provide evidence based practices, interventions, and the language around suicide, safer care.

The other thing that I think about in terms of making sure that everyone is equipped to reach a care provider who cares about them, including our LGBTQ community, is making sure that we are using inclusive language and the messaging around 988 and making sure that everyone knows that they have a safe place to go when they are talking about suicide.

We have seen in our own SAMHSA grant programs, including serving this community, that talking about connectedness, talking about mental health wellness, talking about meaningful living, and as others have testified, moving the language more upstream to where everyone has a place to grow and become their very best self, this language is likely as important as talking about reducing suicide.

Thank you for your attention to this very important transition. The third thing I will say is that we need to make sure that we are building out the entire crisis continuum. 988, as we know, is the starting place.

But there also are plans to go into making sure that our mobile crisis services are well-equipped and well-trained, and also making sure that we are standing up other crisis infrastructure. For example, and there is over 600 CSUs, or Crisis Stabilization Units, operating in the United States right now. That provides a really important and critical part of the crisis continuum to make sure that there is diversion from emergency Departments.

The emergency Departments are wonderful in terms of being able to, when people are well-trained, to address and prevent suicide. But CSUs have a different model. They have a living room model to where you are coming in and treated from a standpoint of recovery from the beginning, and also treated with peer support, with a focus on growing and wellness and recovering from suicide or substance abuse or other host of other concerns.

I thank you for your support and making sure that we are building out the entire continuum to make sure that someone reaches someone well-trained who can respond to their immediate need, but also can put them on the path to long term growth, wellness, and well-being.

Senator BALDWIN. Thank you. Dr. Prinstein, it sounds like you would like to also reply. Please do.

Mr. PRINSTEIN. Thank you. I have spent the last 22 years doing research on suicidal youth, those who are at most risk, and thank you so much for the work you have done to establish 988. It is incredibly important that when folks call, of course, they are getting treatment that is likely to work.

We now only have science to support one approach to treatment, and the vast majority of folks are not trained in that approach. It is very, very important that we increase the training of providers. In addition, it is important that we have culturally competent providers, so folks are able to call and understand the embeddedness of suicidal thoughts within their communities.

When I have done that research, we found that suicidal participants would call 10, 12 outpatient providers and not be able to find anyone who would take their case. We need more people trained in suicide.

We need more people trained to deal with the scientifically evidence based approaches to suicide, in particular. Happy to help in any way that we can.

The CHAIR. Thank you.

Senator Cassidy.

Senator CASSIDY. Thank you all. Dr. Durham, great to see you.

Dr. DURHAM. Great to see you as well.

Senator CASSIDY. For my colleagues, Dr. Durham is a former student, and despite my training, heard has done very well.

[Laughter.]

Senator CASSIDY. And is the only one in the room who recognizes that I am wearing a Mardi Gras tie and trained in New Orleans. Everybody else thinks I can't match colors. Dr. Durham, you mentioned you opened a 56 bed facility. Now, I understand that Massachusetts has a waiver from the IMD exclusions.

IMD, which says that you can only have 16 beds in your facility. And the issue here is both cost, but the perception of going back to the bad old days when we just put people in a big warehouse of the mentally ill and not let them out.

But you mentioned as a positive that you are going beyond the 16 beds to 56 beds. Can you speak to the importance of that waiver or that ability to go above 16? Because I assume these are Medicaid patients?

Dr. DURHAM. Yes, many of them will be—thank you, Senator Cassidy. Again, good to see you as well. Many of them are Medicaid, Medicare, and we do see a very small number of privately insured folks at BMC. But the—BMC is a large safety net hospital for the city of Boston and beyond Boston, and we have never had our own inpatient psychiatric unit.

That has caused increased boarding in our own psychiatric emergency room, in our emergency room period, for decades. So a big investment of the hospital is like where do we send our patients who are on Medicaid or Medicare, because many of the facilities in and around Boston are also full in at capacity? And so it was an investment for our patients essential.

Senator CASSIDY. So just to be sure, unlike the kind of stereotype and the criticism that if you go beyond 16 beds you are just warehousing, here, you find that you are able to provide needed services that otherwise would not be available, correct?

Dr. DURHAM. I am not familiar with what you are talking about exactly, but what I can say is that we do need a continuum of care for mental health.

Senator CASSIDY. Sounds good.

Dr. DURHAM. So we need investment in community, in intermediate resources, and in inpatient level of care, so across the continuum.

Senator CASSIDY. And over 16 beds allows you to get an economy of scale as well as to provide more services. I will add that editorial because that is something for we policymakers to consider just to say that.

Dr. Lockman, in your full testimony, you mentioned the telemental health bill that we are trying to push out, and can you kind of comment upon the ability of allowing telemental health to address the person power shortage of providers that was previously referred to?

Ms. LOCKMAN. Absolutely. So when the pandemic hit at Centerstone, we had never used telling mental health widely, and we couldn't actually find research to understand the degree to which it would be effective, particularly in our population. Our population has a lot of community based needs, a lot of psychosocial barriers, and there was a great need to be able to reach them quickly.

We have done our own research in terms—and actually in part through the SAMHSA grant, so we are so thankful for that Federal funding. And we have seen that providing services via phone or telehealth has about the same outcomes as being seen face to face.

This has allowed us incredible mobility during the time of the pandemic. It has allowed our providers to see more patients, and it has also allowed more people to come and have better access to care that really transverses a lot of psychosocial barriers.

Senator CASSIDY. I am running out of time. To cut to the chase, you would highly recommend that Congress pass my bill.

[Laughter.]

Ms. LOCKMAN. We highly support telehealth services and phone based services for mental health services.

Senator CASSIDY. Sounds great. Dr. Prinstein, you highlight the importance of programs such as the programs for children with a serious emotional disturbance, which Senator Murphy and I were able to get passed as part of a bigger piece of legislation. And the Community Mental Health Block Grant targeting funds that children with serious emotional disturbances.

Now we have heard from States that because it is perceived in the regs that the child has to have a diagnosis of serious emotional disturbance before they would qualify to benefit from these funds, that we should make it clear that the funds could be used for preventive services to prevent a child from developing SED, if you will. Any comment on that?

Mr. PRINSTEIN. Yes. First of all, thumbs up on the toll the Mental Health Improvement Act. Excellent. Science supports that that is working.

Second, yes, there is a huge backlog right now for folks who are waiting to get an individualized education plan from a school psychologist, sometimes waiting years until they can get that diagnosis so they can access those funds.

I agree that having the ability to access funds for preventive services would be fantastic.

Senator CASSIDY. Okay, I am almost up. Now, Mr. Rhyneer, thank you so much for what you do. As someone whose family has being affected by suicide by a young person—I am sorry to be emotional.

Thank you.

I yield back.

The CHAIR. Thank you.

Senator Murphy.

Senator MURPHY. Thank you to this tremendous panel. Thank you, Madam Chair, for convening this hearing. Thank you, Senator Cassidy, for your heroic work, standing up for people with mental illness and learning disabilities. And if I can just for a moment lift up a piece of legislation that Senator Cassidy and I worked on and this Committee supported, we passed legislation through this Committee making real the mental health parity legislation that Congress passed decades ago.

The reality was we told plans to cover mental health just like you cover health the rest of the body, but it didn't work out that way. Plans ended up putting up all sorts of barriers and bureaucracy and red tape in front of getting reimbursement for mental health that they didn't for an orthopedic procedure or an operation on your heart or lungs.

One of the things we did a few years ago is require the Department of Labor and Department of Health and Human Services to do an audit of a select group of insurance plans. And we just got the report. It is both defeating and encouraging. It basically came to the conclusion that not a single insurance plan that they reviewed was in full compliance with parity.

But through these audits, they actually got the plans to change their practices and parameters such that now tens of thousands of mental health consumers are now actually getting what they paid for when they paid their insurance premiums. You know, an example is one insurance plan was covering nutritional therapy for diabetes, but was not covering it for anorexia, bulimia, or binge eating.

Another example was a plan was requiring prior authorization for all outpatient procedures for mental health and substance abuse but was not requiring it for a broad range of orthopedic procedures.

We are finally getting this right, and I wanted to maybe pose this question to you, Dr. Durham, to talk a little bit about your experience in dealing with insurance companies and families who are trying to get reimbursement, and the differences that you see in a big medical system in the way that barriers are put up when it comes to mental health and substance abuse that just don't exist when you are going to get the follow-up treatment on an operation on your knee.

I think we are making progress here thanks to this Committee, but I think we still have a long way to go.

Dr. DURHAM. Thank you, Senator Murphy, for your question. I agree completely that none of this is new to us that are on the front lines that are serving patients day in and day out. That—I

have not read the report fully, but I understand that all in all that insurers are not allowing us to treat people with the best evidence and at all times, whether that is medication, whether that is therapy, whether that is trying to get them into another facility for more intense care.

What happens in our emergency room, for an example, is that we do have to get what we call a prior off, prior to sending someone to an inpatient psychiatric facility. You would never do that with someone who comes in with a heart attack to the emergency room. They immediately go and get the help they need on the medical floor and no questions asked.

We spend hours, sometimes, our social work colleagues, ourselves, our case managers in the emergency room just trying to get someone placed, and at times to the level of where someone like me as a physician has to do a doc to doc to essentially say our case, why do we want this patient to go into an inpatient psychiatric unit?

There are times where we are denied, and we have to figure out another level of care. In the outpatient world as well. I am a child psychiatrist and I see kids in the clinic, and I have been on the phone with an insurer as well when a medication adjustment needs to be made for hours.

My time in the clinical setting, where I should be seeing patients, is spent on the phone trying to essentially get a kid that was always on a medicine, but the formulary changed, and I wanted them to continue that medicine.

We need a lot of help in this area. We need to have parity for physical and mental health and not have to be at the beck and call, if you will, of these prior off.

Senator MURPHY. Very well said. And this is an issue I know that there will be bipartisan agreement on because we are just asking for compliance to the existing law. We don't have to pass a new requirement to insurers. We just have to give the tools to the Departments to make sure that the insurers comply.

I am going to submit a question for the record to the panel with respect to how we get more professionals who are in contact with kids, a little bit of extra learning on mental health first aid and mental health diagnosis.

We spend billions of dollars on training for teachers, for pediatricians, and we could do better by giving a little bit additional help on identifying some of the root causes. And last, let me just say thank you to you, Ms. Rhyneer.

Thank you for speaking truth to power on this issue and for standing up for kids. I am a parent to a teenager and a pre-teen, and so I see the rabbit hole that kids can go down when they are experiencing those first signs of crisis given out online some pretty toxic information and influences are, and I think you have opened our eyes to that with your testimony today. Thank you, Madam Chair.

The CHAIR. Thank you.

Senator Braun.

Senator BRAUN. Thank you, Madam Chair. In March 2021, American Rescue Plan was signed into law, $4 billion to address the opioid epidemic. But with that the lack of anything substantive in terms of trying to crack down on the source. Fentanyl is mostly made in China, trafficked through Mexico. Listen to these statistics. I want the public to hear it mostly.

100,000 Americans have died in the last year due to overdoses. Many of them, if not most of them, from fentanyl. This is the part that is most shocking. In the age group 18 to 45, we have lost more young people from overdoses than COVID, car accidents, and suicides.

It is another example of where spending money was not a solution without real teeth, real substantive directives at the source of it. We visited the Southern border a little less than a year ago and we were going from record low illegal crossings to about 70,000 to 75,000. That is now leveled out at about 170,000.

I mean, appalling. I have got two questions, both for Ms. Goldsby. When it comes to not only the impact on losing lives, but along with workforce to boot, I think we have lost close to 2 million prime age workers due to the fact that they are contending with opioid issues, how much of this issue is directly related to the policies we have on our Southern border where illegal crossings are up, fentanyl comes along with it. How much is that contributed to this tragic loss of life?

Ms. GOLDSBY. Senator Braun, thank you for your question. You know, a couple of things, my expertise rests with prevention, treatment, and recovery service delivery, but from 2018 to 2019 in South Carolina, we were really making headway and saw the number of overdoses leveling off due to all of our efforts and all of the Federal funding with State targeted and State opioid response funds.

Since then, and in the last 2 years, our overdoses have skyrocketed, and we are estimating about 63 percent of our overdose fatalities in 2020 were a direct result of the extremely potent illicit fentanyl and the drug supply.

I think in the last 2 years, we have pivoted to doing everything we can to keeping people alive and implementing evidence based harm reduction and intervention services. We have got naloxone everywhere that we can get it. The lifesaving antidote. With the flexibilities and the funding support from SAMHSA, we have been able to distribute fentanyl test strips to those individuals who may not know what substances they are ingesting as the illicit fentanyl has gotten into the methamphetamine supply and the cocaine supply.

The evidence suggests that people are better able to prevent an unintended overdose death if they use these fentanyl test strips, they are using less of the drug. And every interaction to get these supplies to people on the streets where they are is an opportunity to engage them in treatment services and get them on the path to recovery.

That is where our efforts are focusing so heavily now, and I will say we are not feeling defeated, but it has been a major setback

in the last couple of years with how dramatically things have shifted.

Senator BRAUN. Well, thank you. I think without directly saying so by deduction, you can relate what is happening on the Southern border to what you are grappling with. Senator Markey and I have got two pieces of legislation about increasing provider and patient education.

One is the Label Opioids Act and the other the Safe Prescribing of Controlled Substances Act. Through your work in addressing the opioid epidemic, can you speak to the importance of provider inpatient education and how these bills might impact that? Ms. Goldsby.

Ms. GOLDSBY. Senator Braun, thank you. Sorry. I think the patient and provider education is key and we have a long way to go, especially with our provider education in all of our health care workforce.

I think that has been a theme today that we have talked about folks not understanding addiction and mental health issues as disorders, addiction issues as chronic diseases, and the evidence based services, interventions, and treatment models that address these disorders successfully. And so we have come a long way.

We have invested a lot in our response and in engaging the workforce as such. But I know that we have a long way to go, especially as we contemplate access and what that means for people who are approaching health care providers who don't or don't know how or don't address addiction appropriately.

Senator BRAUN. Thank you. I would like you and the other members of the panel to take a look at these two bills. It would be a small step in at least trying to get more information out there and to weigh in on maybe endorsing both of these pieces of legislation. Thank you.

The CHAIR. Thank you.

Senator Kaine.

Senator KAINE. Thank you, Chair. What an excellent panel of witnesses and my colleagues have asked very, very good questions. I want to first put a challenge on the table that I may be asking my colleagues to help us resolve. Two officers who were here defending the Capitol on January 6 died by suicide in the days right after that attack. Howard Lieberman good was a Capitol Police officer, Jeffrey Smith was a Metro Police officer.

Two other Metro Police officers died by suicide a number of months later. I don't mention them because their families have not reached out and asked for help, and I don't want to presume their intentions. But the families of Officers Smith and Lieberman have reached out for help.

Law enforcement officers, Federal, and State local are generally accorded a death benefit should they die in the line of duty. But law enforcement officers death benefits usually State that a death by suicide cannot be a death in the line of duty. That is a significant injustice that is directly tied to antiquated notions of suicide.

It is often hard to determine whether a death is in the line of duty. If the law enforcement officer dies of cancer, usually the ad-

ministrators of these plans have to go back and determine, well, was the officer exposed to a toxic substance in the line of duty, or is it related to something else? But to declare categorically that no death by suicide can ever be a line of duty death is a fundamental injustice, and both the Smith and Lieberman good families are now taking that up with the respective benefit plans under which they served.

In the military, military suicides are not excluded as line of duty deaths. In fact, an overwhelming percentage of death by suicide of active duty military, they get investigated and the overwhelming percentage of these cases, they are determined to be a line of duty deaths. So this is a really important mental health issue for law enforcement. There is an unjust and antiquated view of suicide affecting these line of duty death determinations.

There are two who served at this Capitol and died by suicide in the days right after the January 6 attack, and they have ongoing proceedings going before the relevant authorities. And so it may be slightly premature, but we may need to address this as a matter of law in the same way that we have allowed active duty military to have a suicide determined to be in the line of duty, law enforcement officers should not be shut off from them.

I want to ask each of you about a passion of mine that has been shared by Members of the Committee and that is the mental health of our healers, keeping our healers healthy. Mental—medical professionals prior to the pandemic had very dramatically escalating rates of suicide compared to the general population, and many medical professionals feel some significant stigma about seeking mental health counseling because of worrying about its effect on credentialing at hospitals or licensing at the State level or what colleagues might think.

Committee colleagues have joined together with me in a bipartisan way to pass the Lorna Breen Act, which I introduced with others on this Committee, named to commemorate a very talented emergency room physician in New York, a Virginia native who died by suicide at the beginning of the real wave of pandemic in April 2020.

But what can we do in the profession to help our healers feel more able to get the help they need?

Mr. PRINSTEIN. Sure. Thank you, Senator Kaine, for bringing that up and thank you for your work in this area. It is, in fact, very important. We are definitely seeing burnout. The mental health care providers are frontline workers too, of course. And we are seeing major burnout and concern among mental health care providers.

In partnership with the CDC, the American Psychological Association has been providing some services for health care providers who are not only experiencing burnout and need psychological first aid training, but also are quite angry and are feeling really challenged by the amount of harassment that they are getting, the amount of victimization that they are being subjected to for treating folks due to COVID, for offering vaccines.

A remarkable amount of frustration that they are experiencing for their patients that they can't get the opportunity to treat because they are overrun with folks who are experiencing COVID and are unvaccinated. There are a variety of things that can be done. As you ask providing concrete support, modeling self-care, psychological first aid training, as I mentioned.

Excuse me, but I wanted to thank you for both of your points really raising this issue of stigma that is still pervading the way that we think about mental health issues versus physical health issues.

I hope that this Committee can be very, very clear that that is sometimes also even reflected in the amount of funding that we provide to develop a workforce in mental health versus physical health care, and that just has to stop. Thank you.

Senator KAINE. My time has expired.

Thank you, Chair Murray.

The CHAIR. Thank you.

Senator Marshall.

Senator MARSHALL. Thank you, Madam Chair. I want to lock in on prior authorization for a second. And my first question is for Dr. Durham. Prior authorization is the No. 1 administrative burden facing physicians today across all specialties. Prior authorization, the No. 1 administrative burden facing all physicians across all specialties.

As a physician myself, I knew of the frustration of having to do this. Talk to a person who may be a non-specialist who wasn't from my area, so I couldn't imagine trying to do a prior off with you on a patient in the E.R., your years of experience, and as an obstetrician, I am trying to tell you who doesn't have—needed inpatient management.

Couldn't imagine doing that. But this burnout is leading to early retirement. It ties up nurses. It is frustrating to nurses as well. It makes us all less productive. I guess my question—and you spoke about this earlier, prior authorization.

My question is, do you ever feel that prior authorization is used to ration care or to delay the care of the patient needs?

Dr. DURHAM. Thank you so much for your question, and as a fellow physician that you understand sort of what we are going through. I do think it delays care. Absolutely, especially in the emergency room context.

We have literally two to 3 hours sometimes just to get someone a bed because we are waiting for the insurance to respond, to give the okay that yes, what you have presented to us meets the criteria for us to get a patient, an inpatient psychiatric bed.

Without a doubt, it delays care. And when we are thinking about an emergency room, we have a lot of patients we need to see. I talked briefly in my testimony about we have been beyond capacity in our emergency rooms, and I think that that is not unique to BMC, but across the Nation during this crisis that people are going in for emergency services.

Awaiting beds, awaiting placement just clogs the system, if you will.

Senator MARSHALL. Thank you. My next question for Dr. Prinstein. We are going to stay on the same subject prior authorization. If there was a streamlined solution, would it be helpful to your specialty—streamlined meaning I would suppose that 10 diagnosis account for 80 or 90 percent of the issues that need to be prior off.

We have Senate Bill 3018. It is bipartisan, bicameral as well. We have 17 sponsors, including 8 Democrats, 9 Republicans, 450 national and State organizations are sponsoring this legislation, which would streamline the prior authorization. Would it be helpful for members in your specialty?

Mr. PRINSTEIN. Yes, I think it would, and thank you. Psychiatry represents, of course, a small percentage, just 10 percent of the mental health workforce. The rest of us are psychologists, social workers, counselors, marriage and family therapists, and thinking of solutions that include all mental health providers is appreciated.

Senator MARSHALL. Thank you. You bet. My next question for Ms. Goldsby. You work in the Department of Alcohol and Drug Abuse Services. Does prior authorization ever impact your patients, especially does it delay care or ration care?

Ms. GOLDSBY. Senator Marshall, we do sometimes see prior authorizations delaying care, particularly for some patients who have insurance benefits when they are needing to be placed on medications.

Senator MARSHALL. And a streamlined approach to those patients would be beneficial to your staff?

Ms. GOLDSBY. Yes, absolutely. No barriers to treatment, yes.

Senator MARSHALL. Okay, Dr. Lockman, kind of same issue, prior authorization in your world. I know you are doing research, more research based. Do you ever sit there and think about some of that where your research leads you to that, will patients have access to it? Are you worried about an insurance company deciding as opposed to evidence based medicine deciding what that patient should be receiving?

Ms. LOCKMAN. Absolutely. I concur. You know, every single hour that we spend navigating pre-authorization to get a patient the evidence based treatment that he or she needs is an hour that could be spent on something else.

You are delivering the care that changes people's lives. It can be spent on also doing the training that you have mentioned is critical. So I think any way that we can cut down on the processes would be helpful so that we can just get people the treatment that they need.

Senator MARSHALL. Okay, thank you so much. I will go to Ms. Rhyneer. Ms. Rhyneer, I am not going to ask you about prior authorization, so that is a good thing. I guess my question for you is, have you experienced some of the mandates, whether it is a mask mandate or vaccine mandate closing down school, how has that impacted the mental health of your students?

Ms. LOCKMAN. I think there has been some silver linings, and of course, I think COVID has exacerbated and introduced new issues. So during typical high school classes, a teacher is one of the first lines of defense. They can catch, you know, changes in a student's behavior, performance, or attitude. But during Zoom classes, I stared at a screen of gray squares. And so the teachers found fewer opportunities to ask, like, hey, are you Okay? How are things going at home? You seem a little off, is there anything you want to talk to or talk about? So that is kind of one bad thing.

But a silver lining, on the other hand, is like, I think the conversation around mental health has become a little bit more comfortable. And so teachers have been like, if you need a self-care, take the day off, go take a walk, do your own thing. You know, let's take the Zoom class off for today, and that was something that was totally okay to do. So I think there is good and bad.

I think I am willing to stay at home for the safety of our community. I also know that for some families, that makes it really hard. And for some families, it is not safe for the student to stay at home.

School is kind of like the safety net or this security blanket to be away from that. And that makes it tough. I don't know if there is a way to say that it was all bad or all good.

Senator MARSHALL. Thank you so much. I yield back.

The CHAIR. Thank you.

Senator Hassan.

Senator HASSAN. Thank you, Madam Chair, and I thank you and the Ranking Member for organizing and approving today's hearing. And to all of the witnesses, thank you so much for being here and for the work that you do. I want to start with a question to you, Dr. Prinstein. Young patients are being forced to wait in emergency rooms for up to a month, hoping an inpatient psychiatric bed will open up. And sometimes in my State, it is more than that.

They have written to me recounting their experiences waiting in hospitals. They describe truly horrific experiences, such as being kept in isolation and going weeks without showers, let alone mental health care.

The situation is so severe that New Hampshire used Federal funds to purchase a local hospital to take these children out of the emergency room. But we know there is more work that still needs to be done.

Even with the purchase of this hospital and now additional beds, there are still long waits in our emergency rooms. What concrete steps can Congress take to effectively reduce youth wait times for urgent mental health care?

Mr. PRINSTEIN. Thank you so much for the question, Senator. I appreciate it. It is the case that once someone, especially a child, is experiencing imminent risk charges themselves and others, they do need to be in a hospital. They do need the constant surveillance. And we might think that adding more hospital beds is the answer. It certainly is an opportunity to make sure we have enough emergency services.

But the problem truly has to be addressed by offering more outpatient providers that can make sure that kids never get to that level of crisis. We have the treatments, we have the science to show that it works. We just need more people to administer those treatments and keep kids from getting to that emergency stage.

750 times more funding to make sure we have enough physicians in this country than what we are providing for our entire mental health care workforce. If we had that, if we treated the likelihood that one out of every five young women will experience a major depressive episode before the age of 25, as we heard Ms. Rhyneer say, in Alaska, one out of every four young people are going to experience severe suicidality, think what we would do if that was a physical health disorder?

We would be training people what to expect. We would be training parents and teachers to spot the warning signs. We would be making sure that everyone had access to treatment the minute that they started showing any symptoms of a physical health illness whatsoever.

But it is happening for depression. And the reason why we are seeing all of this overrun in the hospitals is because we haven't provided the workforce to make sure that we can provide outpatient treatment before we reach that crisis stage.

Senator HASSAN. Well, thank you. And let me follow-up on the points you are making with Ms. Rhyneer and Dr. Durham. It is important that we acknowledge the stigma around mental health in schools. Ms. Rhyneer, you were just talking a little bit about things opening up a little bit and people talk more about it.

I received a letter from a student from Candy in New Hampshire sharing her experience with what she considers is a real lack of awareness in her school. She wrote in part, schools and workplaces are not taking mental health seriously. We do not learn about mental health in school, nor the workplace.

I have seen firsthand the way that these disorders can affect people. It is not seriously talked about, not taken seriously enough. It is powerful to hear students like this young woman talk openly about mental health, and we need to do more to support them. Points you all have been making.

Dr. Durham and Ms. Rhyneer, how can we work with students to end the stigma around mental health? And I will start with Dr. Durham, and then we will go to Ms. Rhyneer.

Dr. DURHAM. Thank you for that question. You know, when I think about the patients I see at BMC in particular, I talked about under-resourced communities, mostly low-income Black and Latinx folks that come and see us.

There is a huge stigma and ethnic minority communities, and we need to start, like many of people have said here in schools at home, but also partnering with other community organizations, the church, other systems of care that people go to other than health care systems, that we can start opening that dialog and thinking more openly, sort of like Claire has done today, telling our stories.

We have a lot of initiatives even within Boston Medical Center, of reaching out and partnering with our local churches. We have

people in our Department that are doing some of that work to start breaking down barriers and stigma so people can come in for treatment.

Senator HASSAN. Well, thank you. Ms. Rhyneer.

Ms. RHYNEER. Yes, I totally agree. I was going to say the same thing, we can support community and local organizations. Some of the ones that I was in was, I was introduced to Aiyana club, suicide prevention trainings, but also MHATS, Mental Health Advocacy Through Storytelling, and that encouraged me to tell my story.

The program is youth led. It is youth founded. A group of incorporated school students working to decrease stigma and increase access to mental health resources through true personal short stories of mental health struggle and triumph. And we run a program, a 12 week program, twice a year, aiming to teach and guide conversations on mental health and storytelling, and then help participants develop their own stories on mental health.

Then all of our participants share the story they have developed at a final live storytelling event, kind of in the style of a moc radio hour or anything else like that. So helping organizations in promoting them and encouraging them and funding them and things like that is really, really important.

It was my own friends at this organization who taught curriculum and helped me tell my story, and it is because of those resources and that education that I opened up to my parents last year and the reason why I am here today.

Senator HASSAN. Well, thank you. And I realize I am out of time. I will follow-up, Ms. Goldsby, with the question to you about telehealth and medication assisted treatment. Thanks so much, Madam Chair.

The CHAIR. Thank you.

Senator Smith.

Senator SMITH. Thank you so much, Madam Chair. And I would like to start by asking unanimous consent to submit, for the record, a letter from AFSCME Council 5 and AFSCME Council 65 in Minnesota on the need for sustainable solutions and long term investments in the mental health care workforce.

The CHAIR. So ordered.

[The following information can be found on page 75 in Additional Material:]

Senator SMITH. Chair Murray and Senator Murkowski, I am so grateful for you holding this hearing and bringing together these experts and colleagues to dig into mental health and substance use disorder challenges. I mean, this is an epidemic, as we have heard today, that is traumatizing our country.

Dr. Prinstein said it so well in his opening remarks, that this emergency is related to COVID, but it is the result of decades of systemic neglect and lack of attention and bifurcating mental and physical health to the detriment of our whole health.

I can tell you, of course, I hear about this from Minnesotans every single day, educators and parents and students especially

who are grappling with significant mental health conditions. And I want to share that this is personal for me for two reasons.

The first is that my mentor, Paul Wellstone, who once held the seat that I have today, led on this issue with Senator, New Mexico Senator Pete Domenici. And through their leadership, Congress passed legislation to get parity for mental and physical health reimbursements in the insurance system.

Now, as we have heard today, we are still climbing up that mountain to get compliance for mental health parity, and we won't stop until we do. But I want to just note their leadership, which was instrumental. And the second reason that this issue is personal to me is that I experienced depression when I was a young person, starting in college and then again when I was a young mom.

I know a little bit about what it feels like to feel like there is something fundamentally wrong with you and there is nothing that can be done about it. There is no solution. And you know, I share my story because I want to—I am thinking about people who are currently suffering from mental health challenges and feel like they are all alone and nobody knows—nobody knows, and that they can't talk about it because of the stigma.

Ms. Rhyneer, I want to particularly thank you for your testimony and for sharing your story. Senator Murkowski knows that I actually also went to East Anchorage High School, so we have a little bit of Anchorage in common as well. But let me go, I am going to stay with you, Ms. Rhyneer. I want to just talk a little bit about mental health care in schools.

Last month, the University of Minnesota released some data, which said that 71 percent of principals in Minnesota are saying that more mental health resources for students would be the most important support that they could get. And I visited schools, and I have seen how this works and what a difference it can make.

Ms. Rhyneer, could you talk to us about why in-school services are important, why they work for students, and kind of how you see they might get it the stigma challenges and other challenges that students have accessing the mental health care that they need.

Ms. RHYNEER. Sure, yes. So school is a great place, just because it is a place where all students are going to be, and you can do a lot of different things in school. You can have the community, you can have the teaching, you can have peers, you can have a door to all working together and your parents too.

Also, we have counselors and—or we want to have counselors and therapists in schools. But alsohaving the curriculum around is really important. You know, I have talked to numerous students who say they didn't realize how bad of the situation they were until years later. Like they never recognized their own systems. They never reached out for help.

Having curriculum in schools is great to have people recognize their own symptoms and be like, oh, I think something is going on. I need to reach out to somebody. That person that they need to

reach out to is, ONC 130, this room down the hall that they can walk down there and say, hey, I really need some help.

That counselor can call the parent and be like, hey, I talked to your kid. Maybe you should talk to them. So it is a really great place to have all those services in one place.

Senator SMITH. It is such a great way of describing what difference it makes. And also, I would say how we can—you are really integrating physical and mental health because maybe you go in to see the school nurse about a stomachache and then the school nurse ask some questions and understands that what you really need there is some underlying issues you need to address around anxiety or depression, and it happens all in one place in the kind of integrated care that we have heard the experts and physicians on the panel talk about.

Madam Chair, as you know—I am sure you know that I have several bills that I have been working on that would expand access to mental health care services in schools, and I am going to be very interested in pursuing these bills and this legislation as we go forward for exactly the reasons that I am Claire just described. Thank you so much.

The CHAIR. Thank you.

Senator Rosen.

Senator ROSEN. Thank you, Madam Chair. And thank you, Senator Murkowski, for holding this really important hearing today, and of course, for the witnesses, for being here. I want to build on what Senator Smith was talking about because it is important that we equip schools with the comprehensive mental health and suicide prevention resources we know are so critical because not just under Smith, but we have heard from everyone this morning schools, our students, we are just facing such a growing mental health crisis.

In the American Academy of Pediatrics, they recently declared a national State of emergency in children's mental health. And in Nevada's Clark County School District, we tragically lost 20 students, 20 students to suicide since the onset of the pandemic in 2020. Those families will never be the same. And so we must do more to keep our students safe, to promote their mental health and their well-being.

Which is why, as Senator Murkowski noted earlier, I am working with her on bipartisan legislation to help provide additional resources to support K-through–12 mental health. And currently the Substance Abuse Mental Health Services Administration, or SAMHSA for short, does not, does not have the authority to provide funding assistance directly to school districts to promote comprehensive health and suicide prevention services.

Dr. Prinstein, given the current mental health crisis in our schools, would legislation authorizing SAMHSA to directly provide targeted and timely resources to K through 12 schools help prevent the mental health challenges before they occur, and of course, address suicide attempts and prevent a suicide from taking place?

Mr. PRINSTEIN. Yes, Senator Rosen. Thank you so much. Hurray, this is a great step and very, very important. The opportunity to

make sure that schools themselves can use their local expertise and their knowledge of what their community needs is a fantastic idea.

I will say, please do keep in mind that school staff are currently overwhelmed and usually turning to psychology and as well as other mental health care providers to teach them about the skills that are needed. Psychologists often do this just out of the goodness of their own heart. There is no reimbursement mechanism.

This starts to become hopefully a far more widespread practice of schools instituting preventive programs throughout entire communities, please do think about ways that psychologists and other mental healthcare providers can be as helpful and dedicate as much time as possible to help teach the school staff what is needed, to use our evidence based assessments to screen for risk, and to use our evidence based interventions to reach and help as many people as possible.

We have many prevention programs ready to deploy, and this is a very exciting opportunity that you are speaking of. Thank you.

Senator ROSEN. Well, you set me up perfectly for my next question, because all 17 counties in Nevada are designated as health professional shortage areas. And so that is why I am really proud of the work being done by University of Nevada Reno, the Master's level students, they are providing mental health counseling services to K through 12 students in nearby Churchill County and hopefully doing some of that other training when they are in the schools that you speak of.

This partnership allows our UNR interns to gain real world experience in a supervised setting while also increasing the access and just the knowledge base for everyone in those schools, particularly right now in Churchill K-through–12 students.

Again, back to Prinstein, this is a model. We are using it in Nevada. How might this model or others that you see, not just in Nevada—how can we lead the way in helping to promote these kinds of partnerships that will address the burnout and critical shortages and get those benefits to the students and teachers as well counselors?

Mr. PRINSTEIN. I think it would be terrific if we had the workforce to be able to do that in all States. Imagine that there were school psychologists enough to deploy and consults with every school out there, not just one per school districts or one per county, sometimes with kids waiting for years before they are able to get an evaluation, meanwhile their parents watch them failing grades and experiencing difficulties, just waiting for that school psychologist to join in.

There are sometimes only one mental health care provider for an entire county or for a 100 mile radius, which makes it very hard to consult with all the school districts that ask us to really play a role in just the way that you are describing.

I think that this approach, coupled with a substantial increase in the workforce, could really be a wonderful model for us to try and change the way that we are thinking about mental health from a prevention approach as well as an intervention approach.

Senator ROSEN. Well, thank you. I appreciate that, and I look forward to working with all of you and my colleagues to promote workforce training in the mental health space. We really need it in so many areas. Thank you, Madam Chair.

The CHAIR. Thank you. And we do have two votes called so that as all the Senators who have questions. Senator Murkowski, do you have any closing remarks?

Senator MURKOWSKI. Just very quickly, Madam Chair. And again, I agree this has been an excellent, excellent panel. You know, when we think about the issue of the issues of mental health and substance use disorders, so much of the response has to be when the individual is ready for it, it needs to be the intervention at that moment, and I was struck—I keep going back to reading Claire's testimony.

Claire, you indicate, you said, while I worked at NAMI, the National Association of Mental Illness, I had to tell people they would be on a waitlist for 9 to 12 months before they would receive care from a caseworker, 3 months before the patient would be even contacted to confirm they could be accepted, another 6 months before they could talk to a caseworker and begin care.

When we talk about the workforce issues, we cannot have a situation, an emergency, a crisis, and have an individual be told it will be 3 months before we know whether you can even receive care. So a lot of focus on the mental health issues.

I will tell you, Dr. Prinstein, when you when you indicated that the United States is No. 1 in the world for suicide rates, we think that money can solve a lot of things, but apparently, we are not directing the resources to these very critical areas of mental health like we need to.

Apparently, we haven't dedicated the resources for the workforce. Apparently, we haven't connected with the younger people and really all across the spectrum, we haven't addressed some of the racial issues that you have pointed out here. So we obviously have a great, great, great deal to do here.

I think that today's witnesses have provided us great insight, but it is a reminder that we have so much to do. So thank you to all of our witnesses and look forward to working on these problems.

The CHAIR. Senator Murkowski, thank you, and thank you for helping us put this together. Thank you to all of our witnesses. Senator Murkowski, you talked about workforce. That clearly is an issue. A number of other issues were addressed. But I think you actually identified one at the very beginning, which we don't talk about enough, and that is, how do we talk about suicide?

I think there is, as you stated, among young people a willingness, a desire, understanding that this cannot be a taboo topic that in fact, we need to have an understanding of it. We need to have a discussion of it.

But it is so hard for so many people to talk about it, as she said, because they fear that they are going to encourage somebody to do it. We all have a lot of learning to do, and we have a lot of learning within our schools and across our communities to deal with this issue.

I look forward to working with you, Senator Murkowski, on that and all of our colleagues. That will end our hearing today. Again, I want to thank Senator Murkowski for joining me today. For all of our colleagues, for a very insightful discussion.

I really want to thank all of our witnesses, Dr. Prinstein, Dr. Durham, Director Goldsby, Dr. Lockman, and Ms. Rhyneer for sharing your time and experience with us.

For any Senators who wish to ask additional questions, questions, for the record will be due in 10 business days, February 15th at 5 p.m..

This Committee will next meet February 8th for a hearing on employment opportunities and challenges for people with disabilities. Committee stands adjourned.

ADDITIONAL MATERIAL

COUNCIL 5, AFSCME,
COUNCIL 65, AFSCME,
January 31, 2022.

The Honorable TINA SMITH
U.S. Senate Committee on Health, Education, Labor, and Pensions,
Washington, DC 20510.

DEAR SENATOR SMITH,

On behalf of the 43,000 working Minnesotans represented by AFSCME Council 5 and the 13,000 workers represented by AFSCME Council 65, we ask that this letter be part of the record of the February 1 hearing on Mental Health and Substance Use Disorders: Responding to the Growing Crisis. For too long behavioral health care has been an afterthought, leaving millions struggling to get the care they need for drug and opioid abuse, mental health, PTSD, and more. This hearing will help put this issue front and center.

AFSCME members who are certified peer recovery specialists, nurses, social workers, counselors, support staff, and other behavioral health care workers help individuals in a range of settings. It's not just a job for them; it's a calling. Our members see the services they provide can offer hope, change the trajectory of a person's life, and help repair fractured families. These workers are on the frontlines witnessing how the job loss, isolation, death, and illness from COVID have traumatized families and increased the risk for depression, anxiety, substance use disorder, and even suicidal ideation. These workers are building the resilience of our communities and healing families, one person at a time. They are ready to help our fellow Minnesotans begin that road to recovery, find their way back from a relapse, and support recovery. They are unsung heroes who deserve our respect.

As you consider developing legislation to improve our Nation's capacity to respond to the growing mental health and addiction crisis, we urge you to recognize that behavioral health staff are the foundation to any solution. Funds that are designed to increase the number of behavioral health care workers are important but not enough. Low pay, unsafe working conditions, and unacceptably high caseloads are factors that contribute to burnout and high staff turnover. Staff burnout and high staff turnover result in waiting lists for treatment, inconsistent care, wasted resources, and poor results. We need sustainable policies that ensure new funding is specifically targeted to rectify staff burnout and high turnover. This is how we can show our respect to this workforce and the clients they serve. We stand ready to work with you to remedy this dire situation.

Sincerely,

JULIE BLEYHL,
Executive Director,
AFSCME Council 5.

SHANNON DOUVIER,
Executive Director,
AFSCME Council 65.

QUESTIONS AND ANSWERS

RESPONSE BY MITCH PRINSTEIN TO QUESTIONS OF SENATOR MURPHY, SENATOR KAINE, SENATOR SMITH, SENATOR LUJÀN, AND SENATOR MURKOWSKI

SENATOR MURPHY

Question 1. How can we better prepare professionals in frequent contact with children and teens, such as teachers and pediatricians, to better deal with young people's unique behavioral health needs?

Answer 1. We need to rethink the ways in which we approach mental health care for all populations, including our youth, by moving away from a focus primarily on crisis management and instead investing more in prevention. Therefore, we must meet kids where they are. This means their schools and communities. Evidence-based comprehensive behavioral health systems in schools provide a full complement of supports and services that establish multi-tier interventions and promote positive school environments.

To help achieve this, teachers need increased training on embedding social and emotional learning in classroom curriculum. This would help build skills such as motivation and engagement, problem-solving, emotional intelligence, resiliency, agency, and relationship-building. To be successful, this must be done in partnership with parents, families, and caregivers.

Finally, it is important to remember that mental health is health. Maintaining siloes between physical and behavioral health makes little sense, hurts overall health care outcomes, and perpetuates stigma around mental health. Most people, children included, receive their health care from their primary health provider. Adopting flexible models of integrating mental health care with primary care—which starts in the way we train providers—is key to increasing access to services for all populations, including children and adolescents.

This also means increasing adoption of evidence-based models of integrated primary and behavioral healthcare. Children and teens routinely receive care in primary care settings, and identifying and addressing behavioral health issues could be made much easier if behavioral health specialists are embedded in those settings as part of the primary care team. Integrating psychologists into pediatric primary care practices through the Primary Care Behavioral Health (PCBH) model gives pediatricians a powerful ally in addressing the behavioral health needs of children, youth, and their families, and has a solid track record of success. Congress should support broader implementation of PCBH and other evidence-based integrated care models by providing stronger assistance and incentives for its adoption by primary care practices and behavioral health providers.

Question 2. How might additional training for these professionals improve supports for young people?

Answer 2. Additional training for these professionals can help bolster early detection and early interventions efforts, which are especially important for young people, as most mental health dis-

orders begin between the ages of 14 and 24. Schools in particular are key to these efforts.

Leveraging partnerships between community and school-based entities can provide training to teachers, administrators, and support personnel, as well as families, students, and community members to recognize signs of emotional and psychological concerns and provide best practices for the delivery of mental health care in schools. To help promote the mental health of all students, educator preparation and professional development programs should also include training on mental health literacy, social-emotional learning competencies, and reducing mental health stigma.

Making training for integrated care service delivery broadly available to healthcare providers would help expand access to this treatment modality. Effective implementation of integrated primary and behavioral healthcare requires more than simply co-locating behavioral health and primary care providers. Research shows that training and technical assistance are frequently needed, since neither general medical providers nor behavioral health providers typically receive training in team-based care.

Question 3. Knowing that we have significant health care disparities stratified by income, race, and geography (e.g. rural areas), how do we ensure health equity in addressing the behavioral health needs of children and teens?

Answer 3. Despite the significant need for access to mental health services among young people, the mental health system remains largely geared toward adults. However, many of the same issues that plague the delivery of mental health care for adults, also arise in efforts to provide such services to children and adolescents: workforce shortages; a siloed healthcare system; and poor reimbursement rates for behavioral health services. These barriers disproportionately impact traditionally underserved and underrepresented populations.

One of the ways in which we can begin to build a more equitable mental health care system is invest in programs that educate psychologists and diversify the field, such as the Graduate Psychology Education and Minority Fellowship programs. Student loan debt, which is carried in significantly larger numbers by psychologists of color, also impedes workforce diversity efforts. Pathways to student loan forgiveness, which also incentivize service in communities with lack of access to care, is critical. Once these professionals are in the field, we must also adequately reimburse them for the care they provide by fully enforcing Federal parity law.

However, mental health does not exist in a vacuum and the psychological well-being of children is frequently tied to the overall health, safety, and stability of their surroundings, such as their communities, schools, and homes. COVID–19 has further strained individuals, families, and communities, with low-income and underrepresented minority populations being affected at even higher levels. Addressing the social determinants of health, including by investing in public education, affordable housing, and food security, is crucial to ensuring psychological health among all age populations, including children and adolescents.

SENATOR KAINE

Even before the COVID–19 pandemic, children across America faced mental health challenges. In 2019, suicide served as the second leading cause of death among adolescents. Further, over the course of the pandemic, nearly two in three young people expressed that they were feeling down, depressed, or hopeless. As we work to address the youth mental health crisis, we cannot forget about our military families and youth that receive services through Tricare.

Question 1. As we strengthen our investment in programs addressing youth mental health, how can we ensure that there is coordination and sharing among the agencies so that children and youth in military families, who rely on Tricare and often receive care in the military health systems, have access to the best practices and innovative solutions these programs provide?

Answer 1. APA strongly encourages the Congress and the DoD to take steps toward addressing DoD IG's recommendations in their August 2020 report, including creating a system-wide staffing plan for MHS for the Behavioral Health System of Care and requiring TRICARE to adhere to the same standardized psychotherapy follow-up assessments currently in place in the Defense Health Agency (DHA). [1] Implementing these, as well as OIG's other recommendations would be a step in the right direction toward guaranteeing access to quality mental health care for our service members and their families.

Additionally, the current, unsustainably low reimbursement rate for mental health providers, including psychologists, through the TRICARE network is limiting the number of outside providers who would be able to serve our men and women in uniform. APA contacted DHA back in 2017 with our concerns [2] but we are unaware of any action taken to rectify this issue. Additionally, the current pandemic has highlighted the disparity in reimbursement rates for telehealth compared to in-person care. Studies have shown that telehealth interventions are just as successful as face-to-face interventions [3], [4], and during the pandemic and beyond, the telehealth reimbursement rate should be equal to the reimbursement rate for face-to-face visits. APA recommends adequately reimbursing psychologists in the TRICARE network and bringing parity to reimbursements for telehealth services. APA additionally recommends maintaining a strong in-house Military Health System by continuing to fund the Uniformed Services University and maintaining medical billets.

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[1] Department of Defense Office of the Inspector General, Evaluation of Access to Mental Health Care in the Department of Defense (Aug. 10, 2020) *https://media.defense.gov/2020/Aug/12/2002475605/–1/–1/1/DODIG–2020–112—REDACTED.PDF*

[2] Letter from APA Practice Organization to Adm. Bono, Defense Health Agency. *https://www.apaservices.org/practice/advocacy/humana-reimbursement-tricare.pdf*

[3] Greenbaum, Z. (July 1, 2020). How well is telepsychology working? Monitor on Psychology, Vol. 51, Issue.5, 46. Retrieved from *https://www.apa.org/monitor/2020/07/cover-telepsychology.*

[4] Bashshur, R. L., Shannon, G.W., Bashshur, N., Yellowlees, P. M. (Feb. 1, 2016). The empirical evidence for telemedicine interventions in mental disorders. Telemed J E Health, Vol. 22 Issue 2, 87–113. Retrieved from *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4744872/*.

SENATOR SMITH

Question 1. What are specific examples of initiatives that you have seen in your work that have done a good job of incorporating mental health into the broader response to COVID–19? What should Congress learn from these successes?

Answer 1. The COVID–19 pandemic caused a seismic reevaluation of how patients are assessed for and receive mental health treatment. Expanded access to new modalities of treatment such as telehealth have extended access to communities that have traditionally struggled to access treatment. Increasing implementation of evidence-based integrated pediatric primary and behavioral healthcare could also significantly increase access to care, improve treatment outcomes, promote healthy development, and aid in addressing social determinants of health. A substantial percentage of patients visiting primary care practices are experiencing behavioral health issues affecting their well-being, including both mental health and substance use disorders or difficulties, and behavioral factors associated with physical conditions or chronic disease management.

More than a decade of research has documented the effectiveness of programs implementing the primary care behavioral health (PCBH) model, the collaborative care model (CoCM), and blended models of integrated care. One of the leading models of integrated care is the Primary Care Behavioral Health Model (PCBH), in which primary care providers, behavioral health consultants (BHCs), and care managers work as a team, sharing the same health record systems, administrative support staff, and waiting areas, and collaborate in monitoring and managing patient progress in order to improve the management of behavioral health problems and conditions.

Generally, the BHC strives to see patients on the same day the primary care provider (PCP) requests help and works with the PCP to implement clinical pathways for treatment. An integrated care psychologist's day may include meeting with a parent of a child exhibiting behavioral difficulties or hyperactivity, seeing a new mother experiencing symptoms of depression, helping another patient manage chronic pain or diabetes, and working with another patient who has recently discontinued using his psychotropic medication. Both patients and providers have reported high levels of satisfaction with PCBH model services. From the patient's perspective, behavioral health services are seamlessly interwoven with medical care, mitigating the stigma often associated with behavioral health services.

The PCBH model is particularly well-suited to use in pediatric care. Interventions and supports to promote children's physical, behavioral, and emotional health can positively influence the long-term trajectory of their health and well-being into adulthood. Almost all children are seen in primary care, and it is estimated that one in four pediatric primary care office visits involve behavioral or mental health problems. Psychologists can be especially helpful in pediatric care because assessing behavioral and emotional issues in children is generally more difficult than in adults, and pediatric education traditionally focuses on children's physical health. In ad-

dition to improving treatment in this area, early childhood behavioral health services can help mitigate the effect of adverse social determinants of health. Ideally, integrated pediatric primary care includes a whole-family approach to services that encompasses screening and services for perinatal and maternal depression, domestic violence, and adverse childhood experiences.

Adoption of PCBH and other integrated care models is often challenging for primary care providers, as they face barriers related to physical office space, the need for improved information technology systems, management procedures, clinical staffing and policies, health records and data tracking practices, and provider education and training. APA supports the provision of Federal financial and technical assistance to aid in the expansion of integrated care, whether provided through partnerships (including state agencies) or through direct aid to primary care providers. Initiatives and incentives to promote integrated care should support implementation of not just PCBH programs, but all evidence-based models of integrated care. Because of differences in providers' patient populations and access to behavioral health providers, there is no "one-size-fits-all" approach to effective integrated primary care. APA urges Congress to continue giving primary care practices the flexibility to choose the model of integrated care that works best for their community.

Question 2. What steps should Congress take to protect tele-mental health access, and what specific policies should be pursued for private federally regulated health plans, which fall under the jurisdiction of the HELP Committee?

Answer 1. As you know, expanded access to mental health services via telehealth is proving to be a literal lifeline to the many Americans who are struggling during the pandemic. This expansion is especially beneficial to individuals in geographic areas and communities that have long lacked access to these services. We know, however, that the pandemic will have a mental health impact that will last far longer than the pandemic itself. We appreciate the Administration's efforts to preserve the current pandemic-era flexibilities on telehealth coverage—for example, its recognition of audio-only telehealth as a vital modality of treatment. However, we also feel that Congress can further support expanded access to telehealth in two primary ways: first, by removing unnecessary barriers to mental health treatment, such as the statutory requirement for periodic in-person visits. To that end, APA asks that the Committee take up and pass the bill you co-sponsored with Senator Cassidy to repeal this requirement, the Telemental Health Care Access Act (S. 2061). Second, to ensure that providers continue to offer telehealth services to the same extent going forward, Members of this Committee can pass legislation requiring private insurance plans to cover mental health services furnished via telehealth on the same terms and at the same reimbursement rates as their in-person counterparts. Specifically, we ask that the Committee introduce and adopt a Senate counterpart to the Telehealth Coverage and Payment Parity Act (H.R. 4480).

SENATOR LUJÀN

Question 1. The pandemic has exacerbated longstanding challenges patients and their loved ones have in seeking behavioral health services. This includes major workforce shortages, months-long waitlists for treatment, and entire regions of the country with no behavioral health providers. While these challenges are nationwide, barriers to care are amplified in largely rural states such as New Mexico. One solution that shows promise is the rise of peer support workers—behavioral health providers who have been successful in their recovery and work in their communities to help others. It is critical that we support these workers and give them resources to combat the burnout and high turnover that prevents us from building an experienced and consistent workforce. What can we do to not only recruit new substance use disorder workforce employees, but also retain those we already have?

Answer 1. APA shares your concern about provider burnout amidst increased demand for mental and behavioral health services. Indeed, the data shows that this phenomenon was clearly present long before the current pandemic. With added demand for services due to pandemic-related stressors, coupled with resurgent rates in abuse of opioids, stimulants, and other substances, we fear that, without prompt action, increased rates of provider burnout will impede providers' ability to provide quality evidence-based care.

One essential step to developing and maintaining an adequate substance use disorder workforce is ensuring that they are adequately paid. Reimbursement rates for substance use disorder staff and programs is notoriously low. In 2017 the State of Virginia implemented the Addiction and Recovery Treatment Services (ARTS) benefit for Medicaid beneficiaries with substance use disorders, with a goal of substantially increasing access to care. The initiative included increased provider reimbursement rates for many existing services, and the addition of coverage for a new office-based opioid treatment model. Since ARTS was implemented, Virginia has seen substantial increases in the number of participating addiction treatment providers and facilities, including a quadrupling of the number of practitioners billing for addiction treatment services above 2016 levels. Treatment rates for opioid use disorders and other substance use disorders have more than doubled with initiation of ARTS.

To increase the size and diversity of the behavioral health workforce, Congress can increase its support for key behavioral health workforce programs such as the Graduate Psychology Education (GPE) Program, the Minority Fellowship Program (MFP), and the Behavioral Health Workforce Education and Training (BHWET) Program. Additionally, to improve the pipeline of behavioral health providers, Congress can support efforts to allow psychology trainees—who receive 500–700 hours of direct patient experience through their training program—to bill for services they provide under the supervision of a licensed psychologist, similar to the flexibilities that medical school trainees currently enjoy. Finally, Congress can take steps to eliminate duplicative and unnecessary administrative burdens on independent practitioners; for example,

while APA supported the policy goals of the No Surprises Act to provide a measure of cost transparency to patients, we are concerned that the way the Administration is implementing No Surprises Act imposes unnecessary burdens on behavioral health practitioners—such as the repetitive preparation "good faith estimates" of costs—that do not further the Act's purposes.

Question 2. We know that patients who are able to receive culturally sensitive behavioral health care and community centered care have improved outcomes. How can we better recruit and retain diverse behavioral health care providers who are able to provide high-quality care to their patients?

Answer 2. In order to better recruit and retain diverse healthcare providers, it would be useful to provide increased funding to programs such as the Minority Fellowship Program that have a proven success record of providing support to a qualified, diverse population of mental health providers. The program provides mentorship and guidance for those interested in serving culturally diverse populations. It may be useful to also offer incentives to those entering the workforce in a diverse community. Incentives could include higher pay, educational opportunities, student loan forgiveness or repayment programs specific to those working directly with diverse populations.

Question 3. In New Mexico, the COVID pandemic has overwhelmed an already strained behavioral health infrastructure. In some cases, patients experiencing substance use disorder or mental health crises wait months to be seen by a provider able to provide treatment. From your experience in the behavioral health space, can you speak to the importance of patients being able to access timely care?

Answer 3. The importance of early intervention—both in response to a short-term crisis and over the long-term trajectory over a child's life—cannot be overstated. Even relatively small investments in children's mental health early in their lives can have clear positive long-term effects. Most common mental health disorders, including those with the greatest morbidity, have onset in childhood or adolescence.[5] Childhood and adolescence provide critical periods for prevention, early detection, and intervention to promote lifetime well-being. Rather than activate resources only when a child experiences a crisis, which may inhibit the long-term effectiveness of treatment, our behavioral health system must focus resources earlier in a child's life and address the factors that led to the child experiencing a crisis in the first place.

SENATOR MURKOWSKI

Military Suicides: The Army in Alaska has experienced numerous suicides from 2016 to 2021, most of them occurred at the remote location of Ft. Wainwright. Army leadership has taken steps to improve quality of life, but suicides continue. Furthermore, aspects of military culture that value toughness and resiliency discourage help-seeking behavior. Studies have shown that some serv-

[5] Kessler, R.C. & Wang, P.S. (2008). The descriptive epidemiology of commonly occurring mental disorders in the United States. Annual Review of Public Health, 29, 115–129.

ice members perceive a stigma attached to seeking mental health care, and express concerns that seeking care will harm their career opportunities.

Question 1. What suggestions would you offer to military leadership to help combat this stigma and encourage military members to seek help when needed?

Answer 1. Improve Access to Direct Care and Purchased Care Systems to Ensure Access to Mental Health Care for our Servicemembers and their Families. The mental health of our Servicemembers and their Families is a critical readiness issue. A 2020 DoD Inspector General (IG) report that found that DoD did not consistently meet outpatient mental health access to care standards for active-duty Servicemembers and their Families. [6] APA has expressed serious concern multiple times in the past few years about network adequacy and cuts to reimbursement rates for psychologists. [7], [8] The IG report shows that the TRICARE network is inadequate to meet the mental health care needs of our Servicemembers and their Families. APA encourages you to improve access to care across both direct and purchased care systems to include holding TRICARE contractors accountable when they fail to meet the needs of Servicemembers and their Families.

Maintain efforts to improve DoD's culture and climate. APA applauds previous efforts to end sexual harassment and assault, root out extremism, and make the DoD a safe place to work for all Servicemembers, regardless of gender, sexual orientation, gender identity, race, ethnicity, or religion. These quick-reaction efforts from the Task Forces to Stand Down must be accompanied by long-term policy changes. Members of the military must be able to rely on and trust their fellow Servicemembers. Any actions that undermine that trust, such as fearing sexual assault, racism, retaliation, or extremism, must be addressed directly at all levels of command. This is a critical readiness issue for the DoD, and we urge Congress to ensure DoD continues these efforts.

Continue to Focus on Suicide Prevention and Lethal Means Safety. As you know, the DoD has been focused on suicide prevention among Servicemembers for several years. Data from previous annual suicide reports and ongoing surveillance indicate that this continued emphasis is greatly needed. [9], [10] DoD's Annual Suicide Report for Calendar Year 2019 found that the primary method of suicide was by firearm for Servicemembers and their Families,

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[6] Department of Defense Office of the Inspector General. (2020). Evaluation of Access to Mental Health Care in the Department of Defense. Retrieved from *https://media.defense.gov/2020/Aug/12/2002475605/-1/-1/1/DODIG-2020-112—REDACTED.PDF*

[7] APA Practice Organization. (2017) Letter to Admiral Bono, Defense Health Agency. Retrieved from *https://www.apaservices.org/practice/advocacy/humana-reimbursement-tricare.pdf*

[8] American Psychological Association. (2020). Letter to Secretary Esper, Department of Defense. Retrieved from *https://www.apa.org/news/press/releases/2020/10/letter-mental-health-access-tricare.pdf*

[9] Department of Defense, Under Secretary of Defense for Personnel and Readiness. (2020). Annual Suicide Report: Calendar Year 2019. Retrieved from *https://www.dspo.mil/Portals/113/Documents/CY2019 percent20Suicide percent20Report/DoD percent20Calendar percent20Year percent20CY percent202019 percent20Annual percent20Suicide percent20Report.pdf?ver—YOA4IZVcVA9mzwtsfdO5Ew percent3d*

[10] Department of Defense, Defense Suicide Prevention Office. (2020). Department of Defense (DoD) Quarterly Suicide Report (QSR) 3d Quarter, CY2020. Retrieved from *https://www.dspo.mil/Portals/113/TAB percent20A—20201112—OFR—Rpt—Q3 percent20CY percent202020 percent20QSR—final—1.pdf*

with rates ranging from 59.6 percent to 78.7 percent across military populations. Lethal means safety is critical to reducing suicide rates among these populations.

Increase Continuity for Separating Servicemembers as they Transition out of Service. Studies have shown that transitioning out of the military to civilian life increases risk for suicide, especially in certain populations. [11] The DoD's in Transition program, the Transition Assistance Program, and Yellow Ribbon Reintegration Program must be fully funded and continuously improved to meet the needs of Servicemembers across active and reserve components. It is also critical that Servicemembers are aware of, and have access to, Department of Veterans Affairs (VA) services. We encourage the DoD to devote more resources to data-sharing with VA and other agencies to ensure a smooth transition to civilian life.

Support Basic and Applied Research. The basic and applied behavioral science research conducted by civilian and uniformed psychologists in the DoD is essential to modernize military personnel and talent management systems and to improve readiness, capacity, performance, and effectiveness at the individual, team, unit, and organizational levels. Basic and applied research is also needed to understand and address the stigma associated with mental health care and ways to ensure fairness toward and the full integration of women and minority groups. Moreover, psychologists should be involved in data analytics and artificial intelligence research to address how human cognitive biases have unintentionally been incorporated into various algorithms. Continued investment in the Minerva Research Initiative and social science research is essential to these efforts and must remain fully funded to strengthen the US national security apparatus. Finally, increased support for Minority Serving Institutions is critical in order to maintain a competitive advantage.

Question 2. What steps would you suggest for leadership to take in order to improve suicide prevention efforts in remote and isolated locations, like Interior Alaska?

Answer 2. Research is needed to better understand the contributors to regional differences in suicide mortality across the United States. Rural areas are highly diverse with respect to their landscapes, demographic composition, and socioeconomic conditions. Studies are needed to identify risk and protective factors for mental health outcomes within different types of rural communities and across the rural-urban continuum.

For rural populations, firearms and poisoning are the most common means of suicide, and those populations are at higher risk for suicide via firearms and pesticide ingestion because of greater familiarity and accessibility. Classification as a military veteran also confers risk; for example, in a study of over five million veterans in the United States, rural veterans were at 20 percent greater risk for suicide than urban veterans. [12] Research reviewing the effec-

[11] Ravindran C, Morley SW, Stephens BM, Stanley IH, Reger MA. Association of Suicide Risk With Transition to Civilian Life Among US Military Service Members. JAMA Netw Open. 2020;3(9):e2016261. doi:10.1001/jamanetworkopen.2020.16261

[12] McCarthy, J. F., Blow, F. C., Ignacio, R. V., Ilgen, M. A., Austin, K. L., & Valenstein, M. (2012). Suicide among patients in the Veterans Affairs health system: rural-urban differences

tiveness of lethal means safety interventions has shown that restricting access to handguns, pesticides or other lethal means for patients with suicidal ideation or training clinicians to recommend lethal means restriction can reduce rates of suicide by these means. [13]

Particularly striking are the suicide rates among adolescents and young adults in these communities. Suicide rates in 2014 for American Indian/Alaskan Native individuals between the age of 15 to 24 years old was 39.7 per 100,000, compared with the overall U.S. rate of 9.9 per 100,000. This rate is more than 3 and a half times the suicide rate for males of all races in the age group. The suicide rate for AI/AN females in the same age group was lower than males at 20.2 per 100,000. However, this rate was still nearly six times the rate for females of all races. [14]

As part of the coordinating role, the NIMH Office of Rural Mental Health Research should collaborate with other departments that are building networks to reach high risk rural populations, including veterans, farmer, ranchers and the agricultural community. The Department of Veterans' Affairs, the Department of Agriculture, the Substance Abuse and Mental Health Services Administration, Health Resources and Services Administration, Indian Health Service and others. Farmers, agricultural and migrant workers face unique stressors. The CDC results on deaths by suicide per capita (by occupation) reveal that these stressors can have tragic effects. Farmers, agricultural workers and their families likely would benefit from stress assistance programs tailored to the specific needs of this population. including such elements as a stress hotline and prescription drug abuse education for farmers, ranchers and agricultural workers.

To achieve health equity for rural and frontier populations, APA recommends taking a population health approach that also recognizes the cultural and geographic diversity of rural and frontier populations, including African Americans, Native American/American Indian, Latinx, Hispanic, veterans, women, farmers, LGBTQ populations, ranchers, migrants, individuals with disabilities and those living in resource-limited areas with declining population density. While the prevalence of mental health disorders is similar to populations in urban settings, rural and frontier communities face unique barriers to care that have been classified broadly in terms of accessibility, availability, acceptability, affordability and stigma, and a robust research agenda should seek to address each of these barriers. [15]

Access to psychologists in rural and frontier communities is of particular concern to APA, which has documented these workforce

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in rates, risks, and methods. American journal of public health, 102 Suppl 1(Suppl 1), S111—S117. *https://doi.org/10.2105/AJPH.2011.300463*

[13] Stewart, E.G. (2018). Mental Health in Rural America: A Field Guide (1st ed.). Routledge. *https://doi—org.ezproxy.lib.vt.edu/10.4324/9781315189857*

[14] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, (2017). Suicide Clusters within American Indian and Alaska Native Communities: A review of the literature and recommendations. HHS Publication No. SMA17–5050. Rockville, MD. Retrieved from: *https://store.samhsa.gov/sites/default/files/d7/priv/sma17–5050.pdf*

[15] Juntunen, C.L., & Quincer, M.A. (2017). Underserved rural communities: Challenges and opportunities for improved practice. In. J.M. Casas, L.A. Suzuki, C.M. Alexander & M.A. Jackson (Eds) Handbook of Multicultural Counseling (4th edition) (pp. 447–456). Thousand Oaks, CA: Sage Publications.

shortages. Of the 734 U.S. counties that were entirely rural, the vast majority (93.6 percent) had no records of licensed psychologists, about 2.4 percent had one to four licensed psychologists, and 4.0 percent had five or more licensed psychologists. [16] Research is needed on specific effective and innovative recruitment strategies for rural mental health providers, including a focus on cultural competence in rural populations.

The expansion of integrated care and telemental health holds promise for improving access to mental and behavioral health care and improving outcomes, but more research is needed to determine the essential components of integrated health care teams and ensure that workforce shortages do not undermine the ability to implement evidence-based interventions in these communities. Research is also needed to increase the availability of evidence-based behavioral health assessment, evaluation, prevention, and treatment within medical practices (in addition to primary care) in rural settings, including barriers to access.

Historically, research takes an urban-centered approach that has not focused on the unique needs of rural and frontier populations when developing or conducting research and implementing interventions. APA supports the greater recognition of the need to develop research programs that recognize the tremendous diversity of, and within, rural and frontier communities. To achieve health equity, community-based participatory research should include community engagement strategies that take into consideration these diverse cultures to increase the participation of rural communities in research and diversify the research workforce. As much of the research on rural health disparities examines disparities between rural and urban communities, additional research could focus on disparities within rural communities. Growing diversity increases the difficulty of fully understanding the psychological characteristics and needs of rural citizens. Culturally competent providers must also recognize the culture inherent in the geographic and social locations of rural citizens and be open to both the challenges and opportunities to supporting rural psychological health and well-being. [17]

In addition to the complexity of rurality itself, it is important to note that other vulnerable populations, including elders and people living in poverty, are over-represented in rural communities. Rural areas also include culturally diverse populations, although this is not consistently recognized. Racial and ethnic minorities in rural areas may live in even more isolated communities (such as American Indian reservation and tribal lands) and often are overlooked in diversity conversations, but that is also changing as rural demographics reflect more ethnic and racial diversity. [18] Some tribes do not recognize traditional diagnoses like major depressive disorder.

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[16] American Psychological Association. (2016). County-Level Analysis of U.S. Licensed Psychologists and Health Indicators. *https://www.apa.org/workforce/publications/15-county-analysis*

[17] Juntunen, C.L., & Quincer, M.A. (2017). Underserved rural communities: Challenges and opportunities for improved practice. In. J.M. Casas, L.A. Suzuki, C.M. Alexander & M.A. Jackson (Eds) Handbook of Multicultural Counseling (4th edition) (pp. 447–456). Thousand Oaks, CA: Sage Publications.

[18] Lichter, D.T. (2012). Immigration and the new racial diversity in rural America. Rural Sociology, 77, 3–35. doi: 10. 0.1111/j.1549–0831.2012.00070.

American Indians and Alaska Natives have a much higher reported rate of distress (13 percent) in comparison to the general population (9 percent). [19]

Refugees and undocumented immigrants are a group which face a number of mental health issues such as PTSD and attachment issues (relevant to family separation both at the border and in general). When traveling to the United States, they face a number of traumatic events like abuse or torture, leading to social adjustment issues. These are very unique problems, which need to be treated with culturally competent care. There are also language and cultural barriers which need to be taken into account. Similar to Native Americans and Alaskan Natives, this group have different cultural understandings of what we would consider a diagnosis. [20]

Considering that much of the research on empirically supported treatments is conducted with urban populations, little is generalizable to rural residents' who often face unique challenges that may act as barriers to care, treatment engagement and retention, and treatment outcomes. Research is needed to more explicitly identify clinical and professional methods and strategies that engage and retain rural patients in behavioral health treatment.

To counter disparities in mental health care there has been a growing momentum to introduce technologies to deliver mental health care remotely. Tele-mental health enables effective care management, expands access to services, and promotes the integration of primary and mental healthcare services. The Veterans Affairs Health Administration has been a leading health care system in delivering these types of services with great success. [21] More recently, due to the global pandemic, telemental health expansion across other health care systems has also shown great promise in offering adequate and timely mental health care. [22] These technologies have been found acceptable to older adult communities. [23]

Despite the advantages of telehealth for care services, several barriers exist. For example, critical issues remain with coverage and reimbursement, licensure, broadband access and adequacy, privacy and policy barriers. There are also concerns related to shortages in the community-based geriatric healthcare workforce shortage in delivering care and using these technologies.

Research on the effectiveness of different modalities of telehealth care delivery in rural communities is needed. While video-based telehealth and telepsychiatry services provide clinicians the opportunity to observe important, non-verbal cues that may have clinical relevance, many rural and frontier residents lack adequate broadband infrastructure to support the delivery of video-based

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[19] Stewart, E.G. (2018). Mental Health in Rural America: A Field Guide (1st ed.). Routledge. *https://doi—org.ezproxy.lib.vt.edu/10.4324/9781315189857*

[20] Stewart, E.G. (2018). Mental Health in Rural America: A Field Guide (1st ed.). Routledge. *https://doi-org.ezproxy.lib.vt.edu/10.4324/9781315189857*

[21] Caver, K. A., Shearer, E. M., Burks, D. J., Perry, K., De Paul, N. F., McGinn, M. M., & Felker, B. L. (2020). Telemental health training in the veterans administration puget sound health care system. Journal of clinical psychology, 76(6), 1108–1124.

[22] Patel, S. Y., Huskamp, H. A., Busch, A. B., & Mehrotra, A. (2020). Telemental Health and US Rural—Urban Differences in Specialty Mental Health Use, 2010—2017. American Journal of Public Health, 110(9), 1308–1314.

[23] Choi, N. G., Caamano, J., Vences, K., Marti, C. N., & Kunik, M. E. (2020). Acceptability and effects of tele-delivered behavioral activation for depression in low-income homebound older adults: in their own words. Aging & Mental Health, 1–8.

services (Graves et al., 2020; FCC, 2020).[24], [25], [26] Prioritizing the effectiveness of other telehealth delivery models to increase access to behavioral health care is warranted given this geographic digital divide.

Research addressing the impact of audio-only telehealth services on mental health treatment access in rural and remote regions is needed. The pandemic has demonstrated significant access related opportunities through audio-only services that have uniquely met rural patients' needs. Rural individuals are more likely to face internet service and technology-based barriers to telehealth services. Audio-only services that rely on phone access is typically more reliable and available in rural areas when compared to internet-based video telehealth services. APA recommends that NIMH invest in research to test multiple tele-mental health delivery systems (e.g., telephone, versus videoconference, or hybrid formats) to address optimal care in rural settings, including for older adults.

Increasing access to evidence-based integrated primary and behavioral healthcare could also aid in preventing suicide in rural areas, especially in conjunction with telehealth. In the primary care behavioral health (PCBH) model of integrated care, psychologists and other behavioral health providers work together with primary care providers in delivering team-based care. Congress should support broader implementation of PCBH and other evidence-based integrated care models by providing stronger assistance and incentives for its adoption by primary care practices and behavioral health providers. Integrated care is already in use by both the Veterans Health Administration and the Department of Defense to improve the identification and treatment of mental health and substance use disorders for their patients.

Schools are important settings for accessing mental health professionals, yet rural students are less likely to have access to school-based mental health services.[27] School-based mental health service is an ever-evolving and growing service that effectively meets the needs of rural and underserved children and adolescents. There are a number of successful school-based programs that have been established and tested by psychologists but relatively few have been specifically implemented or tested in rural schools. In many rural areas, the school bus is the most reliable form of transportation, making school-based settings the optimal setting to access children and families in need. This service presents diverse opportunities for screening, prevention, and treatment of some of our most at-risk rural individuals and families. APA recommends behavioral health services in schools to address rural-urban disparities in access to mental health care. Expanding research partnerships with schools and school-based health centers could dem-

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[24] Lindsay JA, Hogan JB, Ecker AH, Day SC, Chen P, Helm A. The Importance of Video Visits in the Time of COVID–19. J Rural Health. 2021 Jan;37(1):242–245. doi: 10.1111/jrh.12480. Epub 2020 Jun 30. PMID: 32506751; PMCID: PMC7300637.

[25] Graves JM, Mackelprang JL, Amiri S, Abshire DA. Barriers to Telemedicine Implementation in Southwest Tribal Communities During COVID–19. J Rural Health. 2021 Jan;37(1):239–241—doi: 10.1111/jrh.12479. Epub 2020 Jun 30. PMID: 32506685; PMCID: PMC7300815.

[26] Federal Communications Commission. (2021). Bridging the Digital Divide for All Americans. *https://www.fcc.gov/about—fcc/fcc—initiatives/bridging-digital-divide-all—americans.*

[27] Shelton AJ, Owens EW. Mental Health Services in the United States Public High Schools. J Sch Health. 2021 Jan;91(1):70–76. doi: 10.1111/josh.12976. Epub 2020 Nov 8. PMID: 33161576.

onstrate effectiveness in school-based interventions for children and adolescent mental health.

Question 3. On what aspects of military suicide prevention should future congressionally funded research efforts focus?

Answer 3. One of the biggest issues in the military community specifically is the ongoing stigma surrounding mental health and lack of access to resources that Veterans and active Servicemembers feel comfortable accessing. There is still a lot of concern out there that if a Servicemember seeks mental health treatment their career will be derailed, or they will lose security clearance. Research into the current state of this stigma is necessary to develop adequate solutions. Additionally, APA supports the Guarding Mental Health Act that helps to reduce this stigma specifically for U.S. Coast Guard Members.

APA also supports the use of high-quality, evidence based mental health care for the treatment of mental health conditions Veterans are experiencing. When considering non-traditional and innovative approaches in caring for Veterans, they should be done in conjunction with evidence-based care. This is exemplified by the VA's Whole Health approach to care, which focuses on centering the Veteran and caring for them in a more holistic manner. In focusing on traditional and innovative approaches to care, the COVER (Creating Options for Veterans' Expedited Recovery) Commission report includes information about what types of therapies may be useful in caring for Veterans experiencing mental health issues.[28] Critically, the VA must ensure that therapies that do not have evidence are not funded. This funding could be better used for other therapies that have more research showing their efficacy, such as yoga, acupuncture, mindfulness and chiropractic care.

Suicide prevention and lethal means counseling tailored to veterans should be further encouraged, which would require education and training for VA providers and community care providers on lethal means safety and suicide prevention and would direct VA to create a veteran-specific lethal means counseling and suicide prevention session. Nearly 70 percent of suicide deaths were due to firearms, compared to less than 50 percent in the general population.[29] Additionally, APA recognizes the need for workforce development. Scholarship programs for psychologists who agree to work at Vet Centers after graduating are vital to ensuring the VA has the workforce necessary to support current demands.

We support the Access to Suicide Prevention Coordinators Act, which requires VA medical centers to have at least one suicide prevention coordinator on staff and calls for a study on the feasibility of reorganizing suicide prevention coordinators to report to the Office of Mental Health and Suicide Prevention. Suicide Prevention Coordinators are vital to VA's efforts to reduce veteran suicide and ensuring appropriate staffing and prioritization of these positions

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[28] Creating Options for Veterans' Expedited Recovery. United States Department of Veterans Affairs. 2020 Jan. *https://www.va.gov/COVER/docs/COVER-Commission-Final-Report–2020–01–24.pdf*

[29] 22019 National Veteran Suicide Prevention Annual Report. *https://www.mentalhealth.va.gov/docs/data—sheets/2019/2019—National—Veteran—Suicide—Prevention—Annual—Report—508.pdf*

within VA is a crucial step toward lowering rates of veteran suicides.

Congress must also increase Continuity for Separating Servicemembers as they Transition out of Service. Studies have shown that transitioning out of the military to civilian life increases risk for suicide, especially in certain populations.[30] DoD's inTransition program is an excellent resource for servicemembers as they are separating from the service and throughout their career. It is critical that inTransition, the Transition Assistance Program, and the Yellow Ribbon Reintegration Program are fully funded to meet the needs of active duty servicemembers as well as the National Guard and Reserve. It is also critical that transitioning servicemembers know about and have access to Department of Veterans Affairs (VA) services.

DoD and VA-specific services and research must be complemented by suicide prevention programs directed at the broader population, but also available to current and former Servicemembers. Removing barriers to the provision of telehealth services in Medicare, Medicaid and commercial insurers, including allowing audio-only telehealth services, reimbursement parity, the ability providers to practice across state lines are important steps to increase access. Community mental and behavioral health infrastructures also need to be kept from collapse to ensure providers have resources to maintain operations and meet increasing needs of treatment. This includes Medicaid funded community mental and behavioral health centers, other nonprofit community mental health organizations and providers of mental health and addiction services.

Provider Burnout: Throughout the pandemic, I have been concerned about our health care workforce. Now, with a workforce shortage across the country, acute shortages in workers as infected staff isolate, and mounting burnout as we enter year three of this pandemic, I am more concerned than ever about the future of our health workforce.

Question 1. Specifically in the mental health care sector, what steps can we take to help support the mental health needs of health providers, and expand and improve retention in an already-depleted workforce?

Answer 1. APA shares your concern about provider burnout amidst increased demand for mental and behavioral health services. Indeed, the data shows that this phenomenon was clearly present long before the current pandemic. With added demand for services due to pandemic-related stressors, coupled with resurgent rates in abuse of opioids, stimulants, and other substances, we fear that, without prompt action, increased rates of provider burnout will impede providers' ability to provide quality evidence-based care. To increase the size and diversity of the behavioral health workforce, Congress can increase its support for key behavioral health workforce programs such as the Graduate Psychology Education (GPE) Program, the Minority Fellowship Program (MFP),

[30] Ravindran C, Morley SW, Stephens BM, Stanley IH, Reger MA. Association of Suicide Risk With Transition to Civilian Life Among US Military Service Members. JAMA Netw Open. 2020;3(9):e2016261. doi:10.1001/jamanetworkopen.2020.16261

and the Behavioral Health Workforce Education and Training (BHWET) Program. Additionally, to improve the pipeline of behavioral health providers, Congress can support efforts to allow psychology trainees—who receive 500–700 hours of direct patient experience through their training program—to bill for services they provide under the supervision of a licensed psychologist, similar to the flexibilities that medical school trainees currently enjoy. Finally, Congress can take steps to eliminate duplicative and unnecessary administrative burdens on independent practitioners; for example, while APA supported the policy goals of the No Surprises Act to provide a measure of cost transparency to patients, we are concerned that the way the Administration is implementing No Surprises Act imposes unnecessary burdens on behavioral health practitioners—such as the repetitive preparation "good faith estimates" of costs—that do not further the Act's purposes.

Suicide Prevention and Screening: A study from 2016 estimated that 11 percent of ED patients present with suicide ideation. However, only 3 percent of patients were being identified by screening. In addition, upwards of 70 percent of patients who leave the ED after a suicide attempt never attend their first outpatient appointment.

Question 1. I have sponsored a bill, S. 467, that provides direct assistance to hospital emergency departments so they can enhance their ability to screen for high-risk suicidal patients and improves the treatment they receive while in emergency rooms. Do you believe that hospital emergency departments can play important role in identifying and treating suicidal patients who otherwise would never be screened for possible suicide?

Answer 1. As you noted Senator, emergency rooms do provide crisis mental health care in almost every jurisdiction in the country and are often ill-equipped to manage that task. More than 500,000 people present to emergency departments each year with deliberate self-harm or suicidal ideation—both major risk factors for suicide. Up to 80 percent of suicide decedents visit healthcare settings in the year before death, and about a fifth of decedents are seen in healthcare within the week of death, making the delivery of effective interventions a top priority. Legislation such as yours can help improve training, staffing and procedures so that emergency rooms may better manage their mental health patients in crisis, improving the quality and consistency of the care those patients receive. It's critically important to ensure emergency departments have policies of consistent universal screening for suicide risk and resources to ensure their patients can receive follow-up care. Additional funding for research is also important, to understand how services can be targeted to the needs to different populations. Despite advances in treatments over the past several decades, and effective psychosocial interventions that reduce repeat suicide attempts, there remain few evidence-based interventions that have been tested for their rapid-onset benefits for reducing suicide risk.

Role of Social Media and Isolation: As Dr. Murthy highlighted last month, youth mental health and substance misuse has been on the rise even before the pandemic, meaning pre-global pandemic we were failing to address the factors that lead to mental health crisis

and substance misuse in youth. Anecdotally we know that increased screen time and exposure to social media is having an impact on youth.

Question 2.. What efforts are underway to research this impact and better understand the implications and recommendations for care?

Answer 2. There has never been a more important time to examine the impact of social media on children. Psychological scientists, in particular, are increasingly warning that the use of digital media platforms can exploit biological vulnerabilities among.[31], [32] It has long been established that adolescence is associated with neurological changes that promote cravings for social attention, feedback, and status. Research demonstrates that digital media satisfies these cravings at a neural level, activating the same neural regions as drugs.[33], [34], [35] We know that there are ways to beneficially use social media platforms, especially for those individuals seeking to buffer the impacts of negative life events, decrease feelings of isolation, gain a sense of purpose, and experience feelings of acceptance or being understood.[36] And early evidence of technology-based mental health interventions also show promise at treating a range of problems.[37], [38], [39] But users of social media platforms remain uninformed and biologically susceptible to negative outcomes.

Another area of concern among scientists is the heightened potential for peer influence facilitated by digital media platforms. This is exacerbated by the proliferation of misinformation and disinformation campaigns that gain traction specifically due to the accessibility of digital media. Psychological science demonstrates that digital media creates the illusion that expressed opinions represent many others' beliefs and not just the thinking of an isolated

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[31] Crone, E.A., & Konijn, E.A. (2018). Media use and brain development during adolescence. Nature Communications, 9, 1—10. *https://doi.org/10.1038/s41467–018–03126-x*

[32] Wilmer, H. H., & Chein, J. M. (2016). Mobile technology habits: Patterns of association among device usage, intertemporal preference, impulse control, and reward sensitivity. Psychonomic Bulletin and Review, 23(5), 1607—1614. *https://doi.org/10.3758/s13423–016–1011-z*

[33] De-Sola Gutierrez, J., Rodriguez De Fonseca, F., & Rubio, G. (2016). Cell-phone addiction: A review. Frontiers in Psychiatry, 7. *https://doi.org/10.3389/fpsyt.2016.00175*

[34] Griffiths, M. D., Kuss, D. J., & Demetrovics, Z. (2014). Social networking addiction: An overview of preliminary findings. Behavioral Addictions: Criteria, Evidence, and Treatment, 119–141. *https://doi.org/10.1016/B978–0–12–407724–9.00006–9*

[35] Kirby, B., Dapore, A., Ash, C., Malley, K., & West, R. (2020). Smartphone pathology, agency and reward processing. Lecture Notes in Information Systems and Organisation, 321–329. *https://doi.org/10.1007/978–3–030–60073–0—37*

[36] Daine, K., Hawton, K., Singaravelu, V., Stewart, A., Simkin, S., & Montgomery, P. (2013). The Power of the Web: A systematic review of studies of the influence of the Internet on self-harm and suicide in young people. PLoS ONE, 8(10), e77555. *https://doi.org/10.1371/journal.pone.0077555*

[37] Galla, B. M., Choukas—Bradley, S., Fiore, H. M., & Esposito, M. V. (2021). Values—alignment messaging boosts adolescents' motivation to control social media use. Child Development, 92(5), 1717–1734. *https://doi.org/10.1111/cdev.13553*

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[39] Nelson, E. L., Cain, S., & Sharp, S. (2017, Jan). Considerations for conducting telemental health with children and adolescents. Child Adolescent Psychiatric Clinics of North America, 26(1), 77–91. *https://doi.org/10.1016/j.chc.2016.07.008*

user.[40], [41], [42], [43], [44] Participation on digital media platforms changes how we think about what others think. Science demonstrates that this has created a powerful link between young people's Instagram exposure and their offline risk-taking behavior, such as excessive alcohol use.[45], [46] [47], [48]

Increased peer victimization and harassment, as well as more severe discrimination directed toward racial, ethnic, gender, and sexual minorities, represent another serious area of concern. Scientific findings have revealed more frequent and offensive forms of harassment directed toward youths online as compared with offline.[49], [50] Brain scans of adults and youths reveal that these forms of harassment activate the same regions of the brain that respond to physical pain and trigger a cascade of reactions that replicate physical assault and create physical and mental health damage.[51]

Finally, the lack of transparency into the inner workings, policies and measured impacts of these platforms must be addressed. The impact of social media algorithms on the user experience is woefully understudied due in large part to the lack of visibility by researchers into the data and how algorithms work.[52] Social media companies employing algorithms to display content to users should provide explanations on how these technologies work and how they might drive or reward certain types of posts or behavior. Data from

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[41] Dong, G., Zhou, H., & Zhao, X. (2011). Male Internet addicts show impaired executive control ability: Evidence from a color-word Stroop task. Neuroscience Letters, 499(2), 114—118. *https://doi.org/10.1016/j.neulet.2011.05.047*

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[51] Epps-Darling, A., Bouyer, R. T., & Cramer, H. (2020, October). Artist gender representation in music streaming. In Proceedings of the 21st International Society for Music Information Retrieval Conference (Montreal, Canada) (ISMIR 2020). ISMIR (pp. 248–254).

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[1] Press Release: *https://www.bmc.org/news/press-releases/2020/09/09/boston-medical-center-and-proof-alliance-collaborate-reduce-prenatal*

algorithms, along with internal research should also be made public to allow researchers and policymakers to achieve a greater understanding of the impacts of social media on users, particularly children. Federal agencies should prioritize research into the impacts of social media and providing private researchers with grants and other support to ensure findings relating to these platforms are made broadly available.

For a more comprehensive summary of the currently available research in this area, I am attaching a summary of a forthcoming research handbook I co-edited. The Handbook of Adolescent Digital Media Use and Mental Health is scheduled for release by Cambridge University Press in 2022.

Question 3. What methods should we focus on to prevent the onset of substance misuse and mental health disorders in America's youth?

Early detection and early intervention are critical to preventing the onset of mental health and substance misuse disorder among children and adolescents, however a focus on prevention rather than crisis management continues to be rare. As most young people spend a majority of their time in school, school-based mental health care is an essential tool for prevention purposes. Such services can build resiliency and mental health literacy among youth, to both address needs and destigmatize mental health. Leveraging partnerships between community and school-based entities can provide training to teachers, administrators, and support personnel, as well as families, students, and community members to recognize signs of emotional and psychological concerns and provide best practices for the delivery of mental health care in schools.

Furthermore, increased adoption of evidence-based models of integrating primary and behavioral health care is another way to help increase prevention, early detection, and early intervention, while also reducing stigma around mental health, which prevents many ethnic and racial minority populations, including Black, Hispanic, Asian/Pacific Islander, and Tribal, from seeking needed care.

Response by Michelle P. Durham to Questions of Senator Murphy, Senator Kaine, Senator Smith, Senator Lujàn, Senator Collins, and Senator Murkowski

SENATOR MURPHY

Question 1. How can we better prepare professionals in frequent contact with children and teens, such as teachers and pediatricians, to better deal with young people's unique behavioral health needs?

Answer 1. As the Director of Clinical Training at TEAM UP for Children, a pediatric integrated model in federally qualified health centers (FQHCs) in Massachusetts, I see firsthand the impact that targeted staff training and supports can have on quality of care and child health. The TEAM UP for Children model, co-developed by Boston Medical Center (BMC) and partner FQHCs, is based on the National Academy of Medicine's Promotion Framework and focuses on promotion, prevention, early identification of emerging be-

havioral health issues, and swift access to behavioral health services that are delivered by a multi-disciplinary team. TEAM UP for Children enables pediatric primary care providers to better manage common behavioral health diagnoses in the primary care setting through clinical training, quality improvement support, and a team-based model that includes embedded behavioral health clinicians and community health workers. This type of model could be scaled up to serve additional clinical sites and adapted to suit other settings, such as schools, to increase the ability for frontline staff to identify and address children's behavioral health needs, while also making mental health services available in the places where children are.

Question 2. How might additional training for these professionals improve supports for young people?

Answer 2. The goal of this type of approach is really about prevention. In other words, reaching young people before they are in crisis. Bolstering mental health resources and supports in the places where children are—in schools and other community settings—allows for children to be able to access help at the time that they need it. Oftentimes this requires intervening before there is an actual behavioral health diagnosis, which conventional health insurance plans typically don't permit. In July 2021, Massachusetts' combined Medicaid and Children's Health Insurance Program (CHIP) or "MassHealth" added a new integrated behavioral health code to allow mental health clinicians to receive reimbursement for seeing a pediatric patient up to six times without needing a mental health diagnosis *https://www.mass.gov/doc/physician-bulletin—103—integrated—behavioral—health—service—code—description—and—billing—requirements—download.* This type of flexibility shows great promise and could serve as a prevention model other states could emulate.

Question 3. Knowing that we have significant health care disparities stratified by income, race, and geography (e.g. rural areas), how do we ensure health equity in addressing the behavioral health needs of children and teens?

Answer 3. The TEAM UP for Children model is designed to disrupt health care disparities. By strengthening the ability of FQHCs to recognize emerging child behavioral health issues and intervene early with appropriate treatment, TEAM UP for Children aims to improve life outcomes for tens of thousands of low-income children across Massachusetts. Ensuring that mild and moderate cases of common mental disorders (depression, anxiety, ADHD, etc.) can be managed in the pediatric primary care setting, and at FQHCs in particular, which disproportionately serve as the site of care for low-income children and children of color, opens up access to mental health care to a population that historically has high needs but faces the highest barriers to care. Investing in community health workers (CHWs), which play a central role in the TEAM UP for Children model, would also serve to advance health equity. CHWs serve as a bridge to the community as they are often members of the community and are trained to work with families to address basic needs, provide mental health education, and offer school support in culturally and linguistically appropriate ways.

SENATOR KAINE

Even before the pandemic, underserved, rural, and minority communities faced too many barriers in accessing health care, and mental health services are not exempt. This has only been exacerbated by nationwide physician shortages. And, while the number of mental health providers of color has grown in recent years, they still only account for 17 percent of the workforce according to the American Psychological Association. It is clear that we need more mental health professionals. We know that mental health services are delivered by a wide array of professionals, and that primary care providers are often at the forefront of mental health care.

One way we can address this issue is by diversifying and expanding our physician pipeline, as medical students of color and those from rural areas are more likely to practice in the communities they are from. This Congress, I reintroduced important legislation, the Expanding Medical School Education Act, to help us get one step closer to ensuring communities have access to the medical professionals they need. This bill supports the creation or expansion of medical schools in medically underserved communities and at minority-serving institutions, including Historically Black Colleges and Universities.

Question 1. Could you speak to the importance of having cultural and linguistic diversity among mental health providers?

Answer 1. Senator Kaine, thank you for your question and for supporting this important bill. Increasing ethnic, cultural and linguistic diversity in the mental health workforce is critical to engaging diverse communities in treatment. There is great stigma around mental illness and seeking treatment. It is well known that those that do make the first step to treatment, do not feel heard or understood during clinical encounters. At times their symptoms are dismissed, overlooked, or misdiagnosed. We know that racism and discrimination create an unequal system of care for diverse populations. By increasing the diversity in the physician workforce, people can engage in treatment with folks who look like them, share the same faith, understand the language, and understand the person's culture to better inform care.

SENATOR SMITH

Question 1. What steps should we be taking at the Federal level to address the immediate shortage of pediatric mental health beds?

Answer 1. A regional approach to expand the full continuum of care services, not just crisis services, including an emphasis on prevention and moving upstream to address health-related social needs, behavioral health integration in primary care settings, and other means of enabling individuals to access outpatient mental health services when they need it, could lead to reduced reliance on emergency services and inpatient mental health services for children and adults. Timely response is key and can potentially avoid requiring emergency or inpatient-level care.

Massachusetts has several models for investing in prevention that are ripe for replication:

- The Boston Emergency Services Team (BEST)—led by Boston Medical Center—provides a comprehensive and highly integrated system of crisis evaluation, intervention, and treatment services to residents of the Boston-area, including mental health urgent care centers, mobile crisis intervention for youth, community crisis stabilization program for adults, and a jail diversion program.
- Children's Behavioral Health Initiative (CBHI), which initially focused on youth covered by MassHealth (Medicaid/CHIP) and has since expanded to include commercial health insurance, provides coverage for an enhanced continuum of home-and community-based behavioral health services and requires primary care providers to screen for behavioral health conditions as a routine part of care.

Question 2. What are specific examples of initiatives that you have seen in your work that have done a good job of incorporating mental health into the broader response to COVID–19? What should Congress learn from these successes?

Answer 2. Telehealth profoundly expanded access to mental health services during the COVID–19 pandemic. Telehealth enabled BMC to maintain and exceed our pre-pandemic volume of mental health services, with over 90 percent of our outpatient psychiatric visits conducted via telehealth at peak. In addition, show rates to telehealth visits (video and audio-only combined), which to-date hover around 75–85 percent, have exceeded show rates to in-person behavioral health visits pre-COVID–19 by roughly 10 percentage points, suggesting that telehealth has significantly reduced barriers and enhanced timely access to care for our patients.

Even as in-person volume has steadily returned at BMC, audio-only services continue to account for a significantly greater percentage of our ambulatory visit volume compared to video. BMC data demonstrate that a higher proportion of White and English-speaking patients scheduled and completed ambulatory visits via video compared to non-White (particularly Black and Latinx) and non-English-speaking patients. This trend of differential utilization of video care by race/ethnicity and language has been shown to be consistent across diverse medical systems.

We urge Congress to pass the **"Telemental Health Care Access Act of 2021"** to remove the requirement for Medicare beneficiaries to have an in-person visit for mental health services in order to access telehealth for mental health services, and instead allow providers to rely on clinical discretion and patient preference to determine the appropriate treatment modality (audio, video, or in-person).

Question 3. What steps should Congress take to protect tele-mental health access, and what specific policies should be pursued for private federally regulated health plans, which fall under the jurisdiction of the HELP Committee?

Answer 3. In 2021, the BMC integrated behavioral health program launched a pilot telehealth hub for behavioral health coun-

seling visits to take place in community in partnership with a local church. By providing access to video capable technology, high-speed, reliable internet, and a private space in a convenient, trusted location, the pilot seeks to reduce barriers for people to utilize telehealth. The Federal Government could play a role in helping accelerate the development of community telehealth hubs by providing grants to health systems, hospitals, federally qualified health centers, schools, and community-based organizations to purchase equipment, retrofit space, hire staff, and receive or provide technical assistance.

Question 4. Do existing systems of care recognize a developmental disorder such as fetal alcohol spectrum disorders (FASD), or do you believe that a lack of identification could be a significant gap in treating these individuals for their mental health disorders? What are the barriers in integrating FASD-informed identification and care into existing systems?

Answer 4. In September 2020, BMC was awarded a 3-year, $2.9 million Health Resources and Services Association (HRSA) grant to fund the SAFEST Choice Learning Collaborative, a program aimed at reducing the incidence of prenatal alcohol exposure and improving outcomes in children with suspected or diagnosed fetal alcohol spectrum disorders (FASD). The program—which is a joint effort between BMC, Boston University Schools of Medicine and Public Health, and Minnesota-based Proof Alliance—uses the Extension for Community Healthcare Outcomes (ECHO) virtual education platform to provide primary care providers at community health centers in New England and the Upper Midwest with training and support from experts about FASD and how to screen for and counsel women about the risks of alcohol use during pregnancy, as well as train pediatric providers on identifying and caring for children and adolescents with suspected or diagnosed FASD.[1] More information on the program is available on our website: *https://www.bmc.org/addiction/training-education/safest-choice.*

SENATOR LUJÀN

Question 1. Health care worker burnout is devastating given the great debt of gratitude we owe them. That is why I was pleased to support the American Rescue Plan that dedicated $103 million to reduce burnout and promote mental health and wellness of health care workers, which over $1 million went to the University of New Mexico Hospital to support the frontline workers who are sacrificing so much while caring for others. How can burnout be prevented or reduced among existing behavioral health providers?

Answer 1. I prefer the term "moral injury or moral distress" to "burnout" as I believe it better describes the reality facing our Nation's frontline healthcare workers. Both terms point to system failures whereas burnout places the onus on individuals, e.g. the clinicians with symptoms of exhaustion and low productivity. Systems have responded to calls to address healthcare worker burnout with "resilience training" yoga or other individually centered interven-

[51] Epps-Darling, A., Bouyer, R. T., & Cramer, H. (2020, October). Artist gender representation in music streaming. In Proceedings of the 21st International Society for Music Information Retrieval Conference (Montreal, Canada) (ISMIR 2020). ISMIR (pp. 248–254).

tions without changing the system. This kind of misaligned approach is problematic and unlikely to yield the intended results. Moral injury is more than just being overworked—it's the inability for providers to be able to do their jobs, confronting systemic issues that don't change, frequent barriers, and lack of supports.

"Moral injury describes the challenge of simultaneously knowing what care patients need but being unable to provide it due to constraints that are beyond our control."[2,3]

Potential solutions to address moral injury include:

- decreasing administrative burden such as prior authorizations;
- increasing the amount of time clinicians spend with patients especially those that have co-occuring illness and/or need additional support due to housing, financial, and/or food needs;
- parity in payment for physical and mental health treatments.

SENATOR COLLINS

I have heard firsthand from parents and caregivers in Maine who are gravely concerned about a greater incidence of speech development delays in children. Compounding their concerns is the fact that increased absences and continued daycare and preschool closures are still widespread across the country. Parents and teachers have anecdotally raised concerns that this may be related to mask use. Actually seeing people talk is foundational to phonetic development for all children, and especially those with disabilities or learning disorders.

Harvard's Center on the Developing Child explains that, "As early experiences shape the architecture of the developing brain, they also lay the foundations of sound mental health. Disruptions to this developmental process can impair a child's capacities for learning and relating to others—with lifelong implications."

Question 1. Dr. Durham, are children with speech delays at a greater risk of developing mental health problems compared to other children? If so, what are clinicians doing now to prepare for the pandemic's secondary mental health consequences on children?

Answer 1. Children of all ages have the potential to be impacted by the pandemic. Many of the families we serve at BMC have had to work outside of the home throughout the pandemic to continue providing for their families. This meant families living in multigenerational homes often were exposed to the virus. We have seen recent data indicating many children have lost parents and/or caregivers due to COVID–19 (linked below). Grief from death of loves ones, loss of school connections, loss of activities once enjoyed and/or the inability to stay fully connected to friends and family

[2] Dean W, Talbot S, Dean A (2019). Reframing Clinician Distress: Moral Injury Not Burnout. Federal practitioner: for the health care professionals of the VA, DoD, and PHS, 36(9), 400—402.

[3] Epstein EG, Whitehead PB, Prompahakul C, Thacker LR & Hamric AB (2019). Enhancing Understanding of Moral Distress: The Measure of Moral Distress for Health Care Professionals, AJOB Empirical Bioethics, 10:2, 113–124, DOI: 10.1080/23294515.2019.1586008

will impact many across all ages. The Federal Government could ensure that mental health services in schools and in communities are well equipped to support children and their families. In schools, in particular, supports should be in place not only for children, but for staff as well. It is imperative the adults caring for children at schools have the supports they need to continue to be mentally prepared to also be a source of support for children in schools. [4]

SENATOR MURKOWSKI

Mental Health Workforce: I am deeply concerned by the worsening, widespread shortage of mental health professionals, which has only been exacerbated by the COVID–19 pandemic. Over half of Alaska's population, three hundred and eighty thousand Alaskans, live in a designated Mental Health Professional shortage area. Workforce shortages create another serious barrier to accessing mental health care services, especially for those living in rural communities, like many Alaskans. Last May, I joined Senator Smith in introducing the Mental Health Professionals Workforce Shortage Loan Repayment Act. This bill establishes a student loan repayment program for mental health professionals who work in these shortage areas. My hope is that this legislation will help expand the mental health workforce and incentivize professionals to provide much-needed mental health care to those living in rural communities and other underserved areas.

Question 1. What other steps do you recommend taking to address mental health workforce shortages, specifically with regard to the shortages facing Americans in underserved and rural areas?

Answer 1. Congress should consider expanding the list of eligible sites that qualify for the National Health Service Corps (NHSC) loan repayment program as a means to entice more clinicians to enter the mental health field. A promising example of this is the Health Resources and Services Administration (HRSA) Substance Use Disorder Treatment and Recovery Loan Repayment Program (STAR-LRP)—authorized by the SUPPORT for Patients and Communities Act of 2018—which allows certain clinical roles providing substance use disorder treatment to receive up to $250,000 in loan repayment after 6 years. BMC recently became a STAR-LRP approved facility and expects this will be a significant asset to our recruitment efforts. Conversely, BMC, despite being an urban safety-net hospital that provides a continuum of mental health services to historically marginalized communities, does not qualify as a NHSC-approved site, meaning our mental health providers are not eligible to receive loan repayment.

Beyond the shortage of providers, the mental health workforce is not representative or reflective of the U.S. population—for instance, only 2 percent of Psychiatrists identify as Black. In addition to expanding the NHSC loan repayment program for the mental health workforce to include urban safety-net providers, efforts should be directed toward providing greater investment in a racially and ethnically diverse mental health workforce, such as proposed in the **"Pursuing Equity in Mental Health Act" (S. 1795).**

[4] Reference: *https://www.thelancet—com/infographics/COVID-0919—associated—caregiver—deaths*

Question 2. What can and should be done to grow the employee pipeline in this field?

Answer 2. In order to grow the mental health employee pipeline, we must understand that the issue at its root is a pipeline issue that requires holistic solutions. Just as we say in medicine, that a person's zip code is more influential than their genetic code in determining life trajectory and long-term health, where a person lives, the color of their skin, and language they speak is highly determinative of the quality of education and resources available, the level of exposure to the mental health field, and stigma associated with mental illness.

Substance Use: During COVID, we have seen a sharp rise in substance misuse specifically alcohol, the most widely used and misused substance. Unfortunately, a landmark NIH study in 2018 established that 1 in 20 school-aged children are affected by fetal alcohol spectrum disorders—FASD. Because of its significance and its status as an overlooked disability that includes debilitating stigma, I introduced S. 2238, the FASD Respect Act. My legislation establishes common standards of care and increases the capacity to manage FASD in medical and mental health settings.

Question 3. Do you believe pediatricians, psychiatrists, and other professionals need to be better informed about FASD—is knowledge of FASD sufficient in your department? If more education and training is needed, how can that be achieved? How can stigma be lessened for individuals living with scorned behavioral health conditions, like FASD?

Answer 3. In September 2020, BMC was awarded a 3-year, $2.9 million Health Resources and Services Association (HRSA) grant to fund the SAFEST Choice Learning Collaborative, a program aimed at reducing the incidence of prenatal alcohol exposure and improving outcomes in children with suspected or diagnosed fetal alcohol spectrum disorders (FASD). The program—which is a joint effort between BMC, Boston University Schools of Medicine and Public Health, and Minnesota-based Proof Alliance—uses the Extension for Community Healthcare Outcomes (ECHO) virtual education platform to provide primary care providers at community health centers in New England and the Upper Midwest with training and support from experts about FASD and how to screen for and counsel women about the risks of alcohol use during pregnancy, as well as train pediatric providers on identifying and caring for children and adolescents with suspected or diagnosed FASD.[5] More information on the program is available on our website: *https://www.bmc.org/addiction/training-education/safest-choice.*

Suicide Screening in the Emergency Department: A recent CDC report on emergency department visits for people age 12–25 found an over 50 percent increase visits for suspected suicide attempts during early 2021. This not only underscores the devastating mental health impact of the pandemic on our youth, but highlights yet another way that COVID–19 has strained our hospitals and medical staff.

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[5] Press Release: *https://www.bmc.org/news/press-releases/2020/09/09/boston-medical-center-and-proof-alliance-collaborate-reduce-prenatal*

I introduced a bill, the Effective Suicide Screening and Assessment in the Emergency Department Act, to improve the screening and treatment of patients in hospital emergency departments who are at high risk for suicide. It will make sure that we can better identify our most vulnerable mental health patients so they do not slip through the cracks when they are treated in hospitals, and make sure hospitals have the resources they need to provide these critical services.

Question 4. Can you talk about the need for improved suicide screening protocols in the Nation's emergency rooms and, second, do you support efforts to bolster the resources available to emergency rooms so they can enhance their screening for high-risk suicide patients?

Answer 4. Boston Medical Center has a Psychiatric Emergency Department and is the lead agency for the Boston Emergency Services Team (BEST), which provides a comprehensive and highly integrated system of crisis evaluation, intervention, and treatment services. However, I'm fully aware that this is not typical of emergency departments everywhere. While I support screening for high-risk suicide patients in emergency departments, it's absolutely essential that a positive screen result in an appropriate response with access to appropriate resources for follow-up.

RESPONSE BY SARA GOLDSBY TO QUESTIONS OF SENATOR MURPHY, SENATOR SMITH, SENATE LUJÀN, SENATOR MURKOWSKI, SENATOR BRAUN, AND SENATOR SCOTT

SENATOR MURPHY

Question 1. How can we better prepare professionals in frequent contact with children and teens, such as teachers and pediatricians, to better deal with young people's unique behavioral health needs?

Answer 1. More education and training can always be done for all professionals to understand that all behaviors have meaning.

Schools are well positioned to provide mental health and substance use programming and services to youth. In particular, school-based student assistance programs can be effective in providing substance use prevention, mental health promotion, early intervention, referral to treatment and guided support programming and services. As described by the Substance Abuse and Mental health Services Administration (SAMHSA), student assistance programs "integrate trained personnel into schools to support and enhance the work of school faculty, as well as provide direct intervention services to students (Student Assistance: A Guide for School Administrators, SAMHSA, 2019).

For health care professionals, more must be done to integrate training related to mental health and youth into medical education curricula. This includes screening, early identification and referral processes. In addition, more must be done to recruit and train more people interested in serving youth and young adults. Our nation faces a severe workforce shortage—including a shortage of those serving children and teens.

We can also support professionals to be healthy models of emotion and behavior regulation, which implicitly reinforces positive feedback loops, helps children and teens connect with emotions, regulate behaviors, and improve decision-making.

Professionals could also be supported to increase overall comfort addressing difficult conversations with children and parents and caregivers.

Question 2. How might additional training for these professionals improve supports for young people?

Answer 2. Additional training for professionals and increasing pediatric time with young people stands to improve treatment outcomes. As an example, trauma, depression and ADHD present in similar ways. When professionals can get at a distinct and accurate diagnosis young people have improved outcomes.

When professionals feel more confident in their capabilities and practices with unique and difficult behavioral needs young people will be better helped earlier.

Question 3. Knowing that we have significant health care disparities stratified by income, race, and geography (e.g. rural areas), how do we ensure health equity in addressing the behavioral health needs of children and teens?

Answer 3. Focusing more resources, programs, and services on the populations experiencing worse outcomes and less access due to income, race, and location will help ensure better health equity. Moreover, the most significant long-term impact on disparities will occur when the resources, programs, and services are aimed at improving the social determinants well-being overall. Finally, we know the therapeutic relationships for youth and young adults are incredibly important. More work can be done to recruit and train people of color to work in the mental health and substance use fields.

SENATOR SMITH

Question 1. What are specific examples of initiatives that you have seen in your work that have done a good job of incorporating mental health into the broader response to COVID–19? What should Congress learn from these successes?

Answer 1. Rapid implementation of telehealth during COVID–19 isolation measures to deliver mental health and substance use services was an instant solution to many who had challenges with access due to transportation and childcare before the pandemic. Implementing the policy and finance mechanisms that enabled telehealth was done quickly out of necessity. And we are still evidencing the successes of patient engagement and retention to services having eliminated those long-standing barriers. We can learn that a universal and coordinated response for a probable solution or promising practice can advance our goals overall even without urgent circumstances.

Additionally, phone and text availability to mental health and addictions counselors that were implemented during COVID–19 continue to be a utilized connection to care. As the 988-crisis line

is implemented nation-wide we hope to see continued success and development of a service array that meets the needs of all callers.

SENATOR LUJÀN

Question 1. Access to MAT improves patient survival, but some estimate that only 10 percent of those with opioid use disorder can access MAT. I applaud the Department of Health and Human Services under Secretary Becerra's leadership for working to remove barriers that were keeping qualified practitioners from treating opioid use disorder with MAT. As someone working to combat substance use disorder at the state level, what policy recommendations would you make to ensure that there's a broad provider network that's adequately trained in medically assisted treatment?

Answer 1. We are very grateful for the recent policy changes that have given more practitioners greater flexibility to provide MAT. In South Carolina, we have thousands of qualified prescribers who have taken the training allowing them to do office-based buprenorphine treatment. Despite their training and DATA 2000 Waiver approval, most of the practitioners are still not actively treating patients with addiction. Through our years of work with the healthcare community and providers across our state, we believe that earlier experiential practice and training in MAT services will break down the biases that some professionals hold toward people with addiction. Additionally, practical and supported experience earlier in training helps providers feel more confidence in the service delivery.

Question 2. In addition to increasing the workforce, what other barriers are keeping those with substance use disorder from accessing MAT?

Answer 2. There are still strong philosophies among care providers, decisionmakers, and the public that medications for opioid use disorder are simply a substitution for the substances people use illicitly. Many people believe that the only successful recovery is recovery without medications of any kind. This lack of understanding of the science and uniformed narrative drives a bias against evidence-based services, hindering the implementation of the medical services, and deterring people from them.

Question 3. What additional barriers to treatment impact communities of color?

Answer 3. The stigma of substance use disorders and their treatments, the costs of treatment, and stigmatizing attitudes of healthcare workers can all be unique barriers to communities of color. Early intervention programs, prevention services, and education about evidence-based treatment that is developed by local community leaders in trusted community organizations helps ensure cultural and language preferences are addressed. This can lead to improving earlier access to treatment and recovery support. In South Carolina, we work with our faith-based organizations to do this kind of work. Additionally, punitive responses to substance use have disproportionately impacted communities of color. There are higher arrest rates for drug-related offenses for black individuals than white individuals. However, criminal justice systems can evolve to become a point of entry to treatment with diversion and

deflection programs that adhere to standards, and support evidence-based treatment.

Question 4. The first year of the COVID–19 pandemic saw the highest number of overdose deaths on record. Now that Pandora's Box has been opened and opioids are readily available in every corner of our country, we must use every tool at our disposal to save lives. As with MAT, there is growing evidence that harm reduction programs prevent death and connect those experiencing substance use disorder with the resources they need to move toward recovery. Dr. Goldsby, what more can the Federal Government do to support states hoping to expand harm reduction resources?

Answer 4. In December 2021, SAMHSA released a grant funding opportunity for harm reduction programming that was included in the American Rescue Plan Act (ARPA). While only 25 awards are anticipated for the 3-year projects, hundreds of people across the states and territories attended the SAMHSA-supported webinars for the prospective applicants. At least six entities from South Carolina alone applied for the funds to begin and expand their harm reduction programs. DAODAS assisted many of the applicants in their planning conversations with local municipal leaders and community stakeholders. The result of the conversations that stemmed from the funding opportunity is a better understanding of harm reduction activities, and more acceptance of harm reduction as prevention and intervention strategy on the continuum of care. More support for the education of the evidence-based approach, and the implementation of the programs and services will help the harm reduction expand to undoubtedly save more lives.

SENATOR MURKOWSKI

SUD Treatment and Recovery: While treatment receives the bulk of attention and investment from Congress, and prevention has dedicated funding via the Substance Abuse Prevention and Treatment Block Grant (SABG), there are no comparable dedicated funding streams for recovery support services. Once consumers receive treatment, they require a variety of services to help them get their lives on track. These can include housing, job training, the benefits of fellowship, and the services of peer professionals. SUD prevention, treatment, and recovery is a continuum of care and services.

Question 1. Congress has proposed a 10-percent set aside in the SABG so that states may invest in recovery. How do you believe this money would best be spent?

Answer 1. As the Single State Authority (SSA) managing the SAPT Block Grant in South Carolina, we have used existing funds, including SAPT Block Grant funds, to support a number of initiatives along the recovery continuum. For example, we support the development of collegiate recovery programs at our colleges and universities, and the development and growth of several independent recovery community organizations (RCOs) around the state.

From 2018 to 2021 we supported the training and certification of 344 Peer Support Specialists. Many of these peers are now employed by are treatment services providers and recovery community organizations. Because Medicaid and private insurance coverage of

the peer services is so little, we also support the salaries for most of these positions. Additionally, DAODAS has had a long-time partnership with Oxford House Inc. to ensure recovery housing is available across the state. A 10-percent set aside in the SABG, with a corresponding increase in this program, would enable us to build on, expand, and sustain these kinds of programs and services.

Question 2. Ms. Goldsby, are you seeing increased usage of alcohol and other harmful substances among pregnant and parenting women due to COVID–19 and other factors? If so, how is your department responding, and what measures have proven effective in educating the public, training primary care professionals, and increasing access to therapeutic recovery services for women?

Answer 2. In South Carolina we began to worry about pregnant and parenting women specifically in March 2020. As soon as isolation measures due to COVID–19 were put in place we began seeing social media messages reinforcing increased alcohol use and medication misuse for women who were working from home and managing childcare and homeschooling simultaneously. In May 2020, our agency began pushing messages on social media platforms to counter the messages and reinforce healthier coping behaviors and less consumption.

Knowing that some women were drinking more, earlier in the day, and possibly using other substances leads us to believe that many who otherwise would never have had a substance use disorder might have developed one during the last 2 years.

We continue to work with the South Carolina Birth Outcomes Initiative with many partners to include health systems and women's services providers as we advocate for screening brief intervention and referrals to treatment for pregnant and parenting women at medical visits, which is not consistently done currently.

With the December COVID–19 Supplement and the March COVID–19 Supplement to the SAPT Block Grant, we developed and are supporting a statewide call line, and telehealth services as a supplement to our Plan of Safe Care effort follow-up for pregnant and postpartum women identified with substance use issues. It is modeled after the Massachusetts Child Psychiatry Access Program for Moms that promotes maternal/infant/child health for 1 year after delivery. Our program will train and educate healthcare providers in South Carolina on substance use disorders and mental disorders for pregnant and postpartum women. It will provide real-time psychiatric consultation via telehealth, and access to a care coordinator who will provide resources and referrals to women during the 12 months postpartum. This will be transformative for our families and our providers and our state. It is wholly supported by short-term COVID–19 relief funds. We will be looking at ways to sustain this programming to stay on track with non-punitive interventions and care for families that could otherwise have social service intervention.

In South Carolina, we support four Family Care Centers which are residential programs for pregnant and postpartum women specifically designed to deliver family centered services where women receive clinical substance use treatment while living with their baby or young children and receiving therapeutic services to heal-

ing as a family unit. The SAPT Block Grant and Medicaid reimbursement helps supports these Centers.

Finally, we appreciate the funds provided in the Pregnant and Postpartum Women's (PPW) Residential Services Grant Program within SAMHSA's Center for Substance Abuse Treatment (CSAT). This program allocates grants to programs that support family centered services in residential settings. In 2016, the Comprehensive Addiction and Recovery Act (CARA) re-authorized the PPW Residential Services Grant Program, and authorized a pilot program to enhance flexibility in the use of funds to provide family centered substance use services to pregnant and postpartum women in non-residential service settings. We sincerely appreciate both the residential program and the pilot initiative. We hope Congress will continue to support these initiatives.

Question 3. What is your state doing to improve recovery support services, and what lessons can the Federal Government take from your efforts? We are interested in hearing about your progress in both urban and rural areas, and amongst all demographics.

Answer 3. With State Opioid Response funds, we have funded recovery community organizations (RCOs) across the state. While only a couple of RCOs have been established longer than 5 years, we aim to meet the needs of their growth to address urban needs while also meeting the needs of RCOs that are emerging, (or have been established fewer than 5 years) and those RCOs that are new and just establishing themselves as service delivery organizations.

Our funds and technical assistance support implementation and continuation of recovery-based initiatives and programs for persons and families affected by substance use disorders in an effort to reduce the consequences of opioid and stimulant misuse in our state. Our approved strategies that RCOs implement, and allowable use of the funds guide organizations to engage with specific populations and encourage service delivery and outreach to rural areas or locations that bring access to the people in need of services. Examples of this include providing mutual aid groups outside of the organization's walls and immediate geographic area, and providing Certified Peer Support Specialist services in specific locations such as detention centers, hospitals, and to faith-based groups.

In our field we say you should 'meet the person where they are' literally and figuratively. As administrators, we do this with recovery community organizations with the aim of being supportive and collaborative for the best possible outcomes.

We are also currently working with the National Alliance of Recovery Residences (NARR) to support independent recovery residences as they work toward national standards and certification. The South Carolina legislature is considering a bill that would require recovery residences to be certified and adhering to national standards in order to received state funds or referrals. This stands to improve our awareness of the many recovery residences around our state, and ensure adherence to ethical practices and conditions for residents.

SENATOR BRAUN

CDC recently published a report finding that two drugs—para-fluorofentanyl and metonitazene—are being seen more often by medical examiners looking into overdose deaths. They often are taken with—or mixed with—illicit fentanyl, the drug mainly responsible for the more than 100,000 U.S. overdose deaths in the last year. A news report in the Indiana Gazette last Friday stated that U.S. overdose deaths have been rising for more than two decades, but they accelerated in the past 2 years—jumping more than 20 percent in the latest year alone, according to the most recently available CDC data, through June 2021.

Yet, even as the crisis escalates, the Substance Abuse and Mental Health Services Administration (SAMHSA) found that in 2020, only 11.2 percent (nearly 300,000) of people aged 12 or older with a past year opioid use disorder received medication treatment, which reduces the risk for overdose. This data demonstrates a shocking gap between the need for service and access and availability.

Question 1. As a cosponsor of the Mainstreaming Addiction Treatment Act, I'd like to hear from you how we can further increase access to life-saving medication. What other policies are needed to ensure those suffering from opioid use disorder can get the treatment they need?

Answer 1. The recent policy changes that have given more practitioners greater flexibility to practice medication-assisted treatment have helped. Still in South Carolina, we have thousands of prescribers who can treat addiction, but they do not. Many healthcare professionals still do not screen patients for substance use disorders. This obstructs access to care when most people may only ever encounter an opportunity for intervention and treatment with a primary care or hospital experience.

There is still a need for primary care and hospital service practice transformation to include screening, brief interventions, and referral to specialty addiction treatment (SBIRT), as well as the practice of medical treatment for substance use disorders in those settings. This could develop with strong technical assistance, supported practice implementation, and perhaps even with financial incentives. Until our healthcare providers understand and realize the reward and benefit to addressing addiction like they do other chronic diseases, bias and stigma will remain inside of healthcare. Training and practical application stands to change hearts and minds to create access. Still, without local policymakers' understanding of evidence-based treatment, feasibility of more integrated care remains varied. An example of this is local regulation that prohibiting Opioid Treatment Programs or other specialty addiction treatment services to be integrated into other healthcare settings or commercially zoned to convenient and safe geographic locations.

SENATOR SCOTT

SUDs and Treatment Access: Sadly, we are all too familiar with the ongoing addiction crisis in this country, which has been exacerbated by the pandemic. South Carolina, like many other states, is

experiencing high rates of alcohol abuse, opioid abuse, stimulant abuse, and broad polysubstance use. During the pandemic, we saw dangerous substance abuse behavior promoted on social media platforms. For instance, memes, hashtags, and other references normalized day drinking to address the effects of lockdowns, unemployment, and other pandemic-fueled stressors. Sadly, what may have started as a casual way to pass the time, changed consumption habits, and spiraled Americans into addiction.

Question 1. Director Goldsby—Can you discuss the work being done to address these issues in South Carolina, specifically how you're utilizing Federal support to combat not just opioid abuse, but also alcohol and stimulant abuse?

Answer 1. In May 2020 as we began to see social media normalizing drinking to cope with the stressors of the pandemic. We launched our own social media effort creating memes to counter the messages and show support for healthier relationships with alcohol. The messages carried links to the Alcohol Use Disorder Identification Test, quick self-test on our website to help determine risk of alcohol problems.

In June 2020, with the support of a $1.9 million SAMHSA grant award for COVID–19 Crisis Response, we partnered with the South Carolina Department of Mental Health to launch the SC Hopes Mental Health and Addictions Support Line, offering 24/7 telephonic connection to mental health and addictions counselors, and certified peer support specialists. The addictions counselors and peer specialists we engaged to rotate on the call line are all primarily serve in our public system supported by the SAPT Block Grant. Strong TV, social media, and billboard marketing around the state, and the inclusion of Spanish and hearing impaired services has driven use of the line to more than 5,640 calls since June 1st, 2020.

Question 2. Following up here, Director Goldsby—Can you describe some of the difficulties you have encountered in the limitation on what certain programs can be used to treat and whether or not additional flexibility would be helpful to give you additional tools and resources to better combat the broader epidemic?

Answer 2. We were able to use the State Opioid Response (SOR) funds that we had on hand in March 2020 to immediately, almost proactively respond when we knew isolation was going to occur and impact people with substance use issues. While we support a robust public education and prevention campaign about the dangers of and the resources for opioid and stimulant use issues, we were limited in what we could leverage for messaging on problematic alcohol, and problematic substance use more broadly, and had to rely on a limited amount of state funds we had on hand for those efforts.

We have used SOR funds to purchase transportation vouchers for patients to get to and from treatment. This has been helpful short term especially in rural counties when patients would otherwise not access care.

The SOR dollars limit resources to patients who have opioid and stimulant use disorders. As we roll out programs and services like the transportation vouchers, these Federal spending limitations

generate the appearance that to our addiction service providers or our programs favor certain people with certain types of addiction issues. We have relied on a limited amount of state funds we have on hand for transportation vouchers to support people with other substance use diagnoses.

Furthermore, the substance specific funding requires the service providers and the state administration to track dollars to specific diagnoses which adds heavy administrative burden all around that could be alleviated if funds were intended for any substance use disorder diagnosis.

Until the December 2020 and March 2021 COVID relief supplements came to South Carolina, none of the Federal funds we had on hand allowed the purchase of important technology such as phones, laptops, and broadband to support the transition to telehealth services. Luckily, we had a limited amount of state funds on hand to support those needs in early 2020 when the transition occurred.

Rural Access to Opioid Treatment: On January 3, 2022, HHS Secretary Becerra renewed the public health emergency for opioids. The opioid epidemic doesn't discriminate and has touched every community in America. Throughout rural America, including most of South Carolina, access to evidence-based treatment for substance use disorders has always been a challenge. In 2018, the U.S. Department of Health and Human Services' Office of Inspector General released a report that showed 40 percent of all counties in the country didn't have a single medical practitioner able to prescribe buprenorphine, 1 of only 3 FDA-approved medications for treating opioid use disorder. This includes almost a quarter of my own state and disproportionately impacts rural counties across the country.

Question 3. Director Goldsby—Your department has worked with the National Institute on Drug Abuse and the South Carolina Department of Health and Human Services to improve access to treatment for opioid use disorder in rural emergency rooms across our state. What has worked well in bringing treatment for opioid use disorder to rural residents of our state and what can Congress and the Federal Government do to help?

Answer 3. The SUPPORT Act gave practitioners greater flexibility to practice medication-assisted treatment (MAT) extending the privilege of prescribing buprenorphine in office-based settings to other qualifying practitioners like nurses and Physician Assistants. In addition, Federal policy allowing certain practitioners to treat up to 100 patients is a change that helped. Still in South Carolina, we have thousands of prescribers who can treat addiction, but do not. This dynamic is creating an access barrier in rural areas. There is still a need for primary care and hospital service practice transformation to include screening and medical treatment of substance use disorders. This could be developed with strong technical assistance, supported practical change implementation, and perhaps even with financial incentives. Until our healthcare providers understand and realize the reward and benefit to addressing addiction like they do other chronic diseases, bias and stigma will remain inside of healthcare. Training and practical application stands to change hearts and minds to create access.

RESPONSE BY JENNIFER D. LOCKMAN TO QUESTIONS OF SENATOR MURPHY, SENATOR SMITH, SENATOR MURKOWSKI, AND SENATOR SCOTT

SENATOR MURPHY

Question 1. How can we better prepare professionals in frequent contact with children and teens, such as teachers and pediatricians, to better deal with young people's unique behavioral health needs?

Question 2. How might additional training for these professionals improve supports for young people?

Answer 1. Pediatricians should all be taught in universal screening practices utilizing universal screeners such as the Pediatric Screening Checklist and suicide-specific screeners such as the Columbia Suicide Severity Rating Scale

Answer 2. Pediatricians and Teachers could benefit from effective, tailored trainings in brief engagement and intervention strategies:

- Pediatricians who utilize motivational interviewing, a brief (10–15 minute) intervention focused on increasing client engagement in their goals, can increase engagement in mental health care for clients (Desai, 2019; Reinauer et al., 2021)
- For pediatricians who identify a patient that is at risk of harm to themselves or others; safety planning and lethal means counseling are a necessary step to engage in with clients prior to discharge to increase probability the client's crisis is allayed prior to entry in mental health care (Schwartzman et al, 2021; Sisler et al., 2020). Those clients—who are screened, have developed a safety plan/blocked access to lethal means, and have a referral to follow-up care—have a significantly higher chance of getting to their appointment with tools to help them through crises that may present prior to engagement in specialty behavioral health care.
- Effective tailored trainings include those that have a simulation based learning or immersive trainings. These types of trainings are intrinsic to other high stakes environments (i.e., pilots, surgeons, etc.); however, despite strong evidence suggesting high efficacy of simulation-trainings—there is little uptake in behavioral health settings of these types of trainings. Given the high risk nature of suicide and the need for consistent practice—simulation based training may increase mastery and decrease length of booster trainings (Matterson et al, 2018; Carter et al, 2018). In addition, simulation trainings are effective at increasing confidence and preparedness in talking to students about mental health (Green et al., 2020). Therefore, increasing the effectiveness of interventions while increasing systemic feasibility of training. Funding that includes time for institutions to offset revenue as well as pay pediatricians, teachers, and other

relevant staff to participate in simulated training experiences is needed.

This is an area where our Research Institute can offer significant subject matter expertise. As such, should you or any of your staff have any specific questions about simulation training for suicide intervention/prevention—please do not hesitate to reach out to our team.

Both teachers and pediatricians should have support from their superiors to devote the time and space necessary for mental health—this requires cultural and institutional shifts to ensure time and resources are allocated.

- There should be support (either physically or tele-located) for students screened/identified as being at risk for suicide. Pediatricians and teachers could be trained in identification tools and brief motivational enhancement strategies—as mentioned above—then refer to more highly trained specialists and school-based liaisons.
- Specialists and school-based liaisons trained in crisis assessment/triage/intervention could then take on the key roles of suicide risk assessment and triage. Individualized education plans (IEPs) for those students identified at higher risk should include weekly treatment team meetings between counselors/teachers/families/pediatricians/specialists/liaisons. Using this model, pediatricians and teachers could have a key, but minimal role, which would allow for them to focus on the primary jobs that they have been trained to do.
- Ultimately, expanded and consistent funding or reimbursement/coverage for school-based and emergency-room based mental health liaisons, as well funding for the necessary training in crisis strategies, would greatly improve continuity of care between identification of students at risk and engagement with these students.

Quicker and prolonged engagement in treatment. Research suggests that children that engage in care as fast as possible after identified and those that receive more consistent care get better faster than those who have lag times between identification and treatment (see samhsa.gov at *https://ncsacw.samhsa.gov/files/rpg-ta-brief-referral-engagement.pdf)*.

Finally, we can have all the best evidence and training in the world, but without the workforce—our response to the current (and projected growing) need will be woefully insufficient. Above all other policy measures, we urge that Congress prioritize policy solutions to address the mental health staff shortages.

To this end, we strongly urge that Congress consider both short-term emergency and long term policy solutions to address the current gap in the workforce. Following we outline one short term measure Congress can immediately take as well as longer term policy solutions to address the behavioral health workforce crisis in America.

With regard to short-term solutions to the behavioral health workforce crisis, we urge Senate HELP and Finance to consider short/medium-term, emergency measures to ensure providers have tools to better recruit and retain their workforce. According to Centerstone's own internal exit interview data, staff leaving cite salary as the No. 1 reason they are leaving. As such we suggest the introduction of the following new, emergency grant program:

- Introduce an Emergency Workforce Funding Bill
- Create a new grant program, that community/safety net provides could apply to request funding to support retention bonuses, wage increases, and more to incentive workforce recruitment and retention for front line staff
- Eligible Provide Types
- Psychiatrists
- Physicians with a buprenorphine waiver
- Psychologists
- Nurse practitioners with a buprenorphine waiver
- Physician assistants with a buprenorphine waiver
- Clinical social workers
- Licensed mental health counselors
- Licensed marriage & family therapists
- Case managers
- Peer support specialists

Use of Funds. The eligible entities described below are permitted to use the funds toward:

- Retention bonuses
- Hazard pay
- Overtime
- Shift deferential pay (wage increases)
- Other additional compensation and employee benefits deemed by the Secretary as necessary to retain clinical staff

In terms of long term solutions to address the behavioral health workforce crisis, we suggest the following legislative vehicles which we believe get at longer term, systemic barriers that restrict workforce and access to evidence-based behavioral health services:

- Pass the Excellence in Mental Health and Addiction Treatment Act of 2021 (S. 2069).
- We see this legislation as the single most critical piece of legislation that Congress can pass to increase training for evidence-based practices, elevate the quality/standard of care in community mental health settings, and address long standing workforce barriers through the Prospective Payment System (PPS) payment methodology that allows providers to offer more competitive wages to their frontline staff. Furthermore, Certified Community Behavioral Health Clinics (CCBHCs) are required to serve patients regardless of payer type and

offer a wide area of required services, including mobile crisis and crisis stabilization.

- Full implementation of this model can take a couple years; thus, we recommend that Congress take shorter term measures—as noted above. That being said, in the long term—this legislation is probably the most critical piece of behavioral health legislation Congress can pass in 2022 to transform the community mental health system.
- Pass the Behavioral Health Services Crisis Expansion Act (S. 1902).
- Coverage is a key component toward ensuring that services are sustainable and available to consumers in a time of crisis. Ensuring that both public and private payers cover crisis services can drastically increase availability and access for consumers when they need it most.
- Ensure that any telehealth extensions include a delay of the in-person requirement on telemental health services, as outlined in The Telemental Health Care Access Act (S. 2061).
- This in-person requirement of telemental health services—if implemented—will further encumber already overworked providers to arbitrarily delineate between their patients on "who gets what type of service" based on diagnosis, rather than clinical presentation and best practice. This approach is counter to the gold standard of providing the "right care at the right time" to improve patient and population health outcomes. Passage of S. 2061 would address this barrier.

Finally we urge passage of the Mental Health Access Improvement Act of 2021 (S. 828).

- This legislation would add other master's level therapists (i.e., Marriage & Family Therapists, etc.) to eligible providers under Medicare (which is currently restricted to only Licensed Clinical Social Workers). Passage of this legislation would allow our behavioral health workforce to work with the full scope of their training and education.

In conclusion, in order to better prepare professionals in frequent contact with children and teens, we need mental health professionals to refer them to. Employees are leaving the mental health workforce at a rapid pace due to low wages and high stress. To address the behavioral health workforce crisis—that is particularly elevated in community, not-for-profit mental health settings—we need Congress to pass legislation that ensures providers have the tools they need to not only recruit and retain staff, but to elevate the quality of care—while increasing access.

Question 3. Knowing that we have significant health care disparities stratified by income, race, and geography (e.g. rural areas), how do we ensure health equity in addressing the behavioral health needs of children and teens?

Telehealth

Answer 3. We know that telehealth has increased access to care for clients that otherwise have difficulty with transportation or scheduling. In fact, we also know that treatment for depressive symptoms using telehealth services is equivalent to face-to-face services in reduction of depressive symptoms based on evaluation data from our CCBHC during the COVID–19 pandemic (unpublished data, 2022).

988 and Crisis Services

- As we look toward addressing health disparities in addressing the behavioral health needs of children and teens—there is tremendous opportunity to ensure the Nation's new 988 three-digit dialing code for the National Suicide Prevention Lifeline (set to launch July 16, 2022) and corresponding services through the crisis continuum are culturally competent and meets the needs of vulnerable, marginalized populations. Specifically:
- Crisis teams, ideally, should reflect the diversity of the communities served and ensure community response and stabilization services meets the needs of everyone in the community; and
- Congress can urge SAMHSA to develop child-focused crisis engagement guidelines to emphasize both evidence-based strategies specific to child and adolescent populations as well as provide further guidelines toward ensuring services address long-standing health disparities.

SENATOR SMITH

Question 1. What are specific examples of initiatives that you have seen in your work that have done a good job of incorporating mental health into the broader response to COVID–19? What should Congress learn from these successes?

Telehealth expansion

Answer 1. We know that telehealth flexibilities availed through the COVID–19 Public Health Emergency has increased access to care for clients that otherwise have difficulty with transportation or scheduling. In fact, we also know that treatment for depressive symptoms using telehealth services is equivalent to face-to-face services in reduction of depressive symptoms based on evaluation data from our Certified Community Behavioral Health Clinic (CCBHC) during the COVID–19 pandemic (unpublished data, 2022). Additionally, initial findings indicated that a cohort of clients receiving telehealth medication assisted treatment (MAT) experienced a 9 percent reduction in average days using any substance, a 29 percent reduction in average days depressed or anxious, and a 9 percent increase in treatment satisfaction at 6 months relative to face-to-face clients (Hanauer, M., Moore, J. T., & Lockman, J, 2020).

- To that end we thank you and Senator Cassidy for your leadership on Telemental Health Care Access Act—S. 2061. The Telemental Health Care Access Act would

provide continuity in behavioral health care access by removing the statutory requirement that Medicare beneficiaries be seen in person within 6 months of being treated for a mental health service via telehealth. We strongly urge that this provision be included with any extension of telehealth flexibilities—as is currently being considered for the fiscal year 2022 omnibus spending bill.

Increasing engagement

Utilizing funding from our SAMHSA Emergency Response for Suicide Prevention grants, we were able to form a team of clinicians to deploy suicide prevention strategies in novel ways that increase engagement and decrease resources. In Indiana, our staff utilized a weekly suicide screen/safety plan review approach with bachelor's level unlicensed staff. Those staff would then refer onto master's level counselors for further assessment if the client screened positive for increasing suicide risk. In addition, these clients could be seen biweekly for suicide-specific treatment, which allowed for decreased resourcing (as opposed to weekly visits for screening/safety plan review with a bachelor's-level staff person).

- To ensure on-going engagement for those in a mental health crisis, we strongly urge that Congress consider passage of the Behavioral Health Services Crisis Expansion Act (S. 1902) as a crucial component to financing the crisis care continuum via ensuring coverage as well as the Excellence in Mental Health and Addiction Treatment Act of 2021 (S. 2069) which advances the CCBHC model—a model in which care coordination, access, and crisis services are required components of the care delivery model.

SENATOR MURKOWSKI

Suicide Screening in the Emergency Department: A recent CDC report on emergency department visits for people age 12–25 found an over 50 percent increase visits for suspected suicide attempts during early 2021. This not only underscores the devastating mental health impact of the pandemic on our youth, but highlights yet another way that COVID–19 has strained our hospitals and medical staff.

I introduced a bill, the Effective Suicide Screening and Assessment in the Emergency Department Act, to improve the screening and treatment of patients in hospital emergency departments who are at high risk for suicide. It will make sure that we can better identify our most vulnerable mental health patients so they do not slip through the cracks when they are treated in hospitals, and make sure hospitals have the resources they need to provide these critical services.

Question 1. Can you talk about the need for improved suicide screening protocols in the Nation's emergency rooms and, second, do you support efforts to bolster the resources available to emer-

gency rooms so they can enhance their screening for high-risk suicide patients?

Suicide Screening

Answer 1. It is admirable and vital to increase suicide screening protocols to better catch high risk patients. To do so comprehensively, two specific actions are required.

First, funding is needed to study and administer adaptive screening measures (see King et al., 2021) that have been found to be best at predicting future suicide attempts and to study upstream screening measures (such as measures of interpersonal drivers of suicide) to better understand why people are driven to suicide and treat these drivers upstream so fewer people are thinking about suicide. Both of these types of measures would be exceptional in an emergency department screening.

Second, to match the increased need for suicide screening and supports in emergency rooms we need to answer the following question: what happens to those individuals after the emergency room? How do we improve continuity of care post-screening? If a person is coming into the emergency room for suicidal thoughts or a suicide attempt, they are in a vulnerable space and needed to be treated with respect, transparency, honesty, and be given the hope that things will change. We support resources dedicated to screening and assessment in hospitals with a caveat; that these changes also support triage and engagement practices with follow-up care. Post hospitalization is the most critical risk period for suicide known to researchers, with rates of suicide 100x higher than the global suicide rate in the 3 months following hospital discharge (Chung et al., 2017). Screenings and assessments are only good for hospital emergency rooms if they can quickly triage and transport patients. Screenings and assessments in hospital emergency rooms are only good for the behavioral health of our clients if they are respected and cared for enough to be connected with immediate follow-up care. Therefore, funding for resources not only for screening and assessment practices but also triage, transportation, and engagement with intensive outpatient or outpatient mental health treatment is necessary. Continuity of care to the crisis continuum is key for comprehensive suicide prevention

To that end, we applaud and thank your and Senator King's leadership in advancing the Effective Suicide Screening and Assessment in the Emergency Department Act of 2021 (S. 467). We support the passage of this bill, and appreciate that the legislative text specifically emphasizes "enhancing the coordination of care for such individuals after discharge" as well as the provision which requires grantees "to establish and implement policies and procedures with respect to care coordination, integrated care models, or referral to evidence-based treatment to be used upon the discharge from the emergency department of patients who are at risk of suicide." Thank you for your leadership for this highly vulnerable population.

SENATOR SCOTT

Question 1. According to the U.S. Department of Health and Human Services, 20 percent of children and adolescents experience some type of mental health issue during their school years and a 2019 report by the Substance Abuse and Mental Health Services Administration stated that "Among the 3.8 million adolescents ages 12–17 who reported a major depressive episode in the past year, nearly 60 percent did not receive any treatment." Can you speak to the role of telehealth in expanding access to mental and behavioral health services for children in school-based settings and opportunities for public-private partnerships?

Answer 1. Telehealth allows the opportunity for more children in school-based settings to connect with psychiatrists, nurse practitioners, psychologists, and more who cannot be physically integrated into the school setting due to lack of resourcing. Centerstone does not have any public-private partnerships in school-based settings, but we have partnered in adult crisis diversion settings with private funders (e.g., Cook Medical Group in Indiana) to match funds raised by Centerstone and their partners in the Bloomington, Indiana community.

With regard to our public-private partnership in Indiana, the Stride Center fulfills a community-wide need for people experiencing substance use or mental health crisis who need a connection to care and a place to go rather than hospitalization or imprisonment (this is often referred to as crisis receiving or stabilization). Many times the options for an individual in a moment of crisis are hospitalization or jail, both of which are more costly and do not treat presenting symptoms or diagnosis. The goal of the Stride Center is to deescalate the situation and connect the guest with appropriate treatment resources (i.e., the right care at the right time). To date, the average amount of time for law enforcement to complete a drop off at the Stride Center is under 5 minutes; whereas processing for jail or the emergency department is 2 hours—saving both time and money through allowing law enforcement to spend their time addressing criminal activity and individuals in need of mental health or addiction treatment care—to receive the care they need. From our experience, public-private partnerships can add immense value to community-based services and the associated outcomes.

[Whereupon, at 12:08 p.m., the hearing was adjourned.]

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