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CARING FOR OUR KIDS: SUPPORTING MENTAL HEALTH IN THE TRANSITION FROM HIGH SCHOOL TO COLLEGE

HEARING

BEFORE THE

SUBCOMMITTEE ON CHILDREN AND FAMILIES

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

UNITED STATES SENATE

ONE HUNDRED SEVENTEENTH CONGRESS

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ON

EXAMINING CARING FOR OUR KIDS, FOCUSING ON SUPPORTING MENTAL HEALTH IN THE TRANSITION FROM HIGH SCHOOL TO COLLEGE

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C O N T E N T S

STATEMENTS

WEDNESDAY, NOVEMBER 30, 2022

CARING FOR OUR KIDS: SUPPORTING MENTAL HEALTH IN THE TRANSITION FROM HIGH SCHOOL TO COLLEGE

Wednesday, November 30, 2022

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

The Subcommittee met, pursuant to notice, at 10:01 a.m., in room 430, Dirksen Senate Office Building, Hon. Robert Casey, Chairman of the Subcommittee, presiding.

Present: Senators Casey [presiding], Murphy, Kaine, Hassan, Smith, Cassidy, Marshall, and Tuberville.

OPENING STATEMENT OF SENATOR CASEY

The CHAIRMAN. This hearing will come to order. I want to thank everyone for being here, especially our witnesses, for their testimony today and the expertise they bring to bear, as well as traveling to be with us.

I want to thank Ranking Member Cassidy for his leadership on these issues, as well as working with us and our two staffs to arrange this Subcommittee hearing. I don't think it comes as news to many Americans that our Nation faces a crisis in adolescent mental health.

At any given time, 1 in 5—1 in 5 adolescents are experiencing a mental, developmental, or behavioral disorder. The COVID–19 pandemic placed a heavy burden on young people struggling with their mental health.

One survey of high school students found that 44 percent persistently felt sad or hopeless. In addition to that survey, we know of other surveys that find similar results. We know, for example, that about half of all people who experience a mental health condition begin presenting symptoms by the age of 14, making high school a critical intervention point.

The Biden administration and the 117th Congress has recognized the importance of mental health support in our schools and have made critical investments in our communities to this end. It is critical that students, particularly those with disabilities, feel both academically and emotionally supported in their schools.

Most schools have some mental health supports in place, like peer support, one on one counseling, and outside care referrals. But

many students are falling through the cracks. To reach every student, we need all hands on deck.

That means far more mental health professionals and making every student, every caregiver, teacher, and school staff member a part of the solution to teen mental health crisis. In 2021, the average ratio of students to school counselors was 415 to 1, despite a recommended ratio of 250 to 1.

We cannot expect progress in addressing this crisis without lifting up professionals in such high impact settings. We must do more to identify and help secondary students in need of mental health support, especially as they prepare for college. The transition to college is, of course, both exciting but also very stressful and a very stressful time for our teens.

Living away from home and an emotional support system for the first time, it is easy for students to be caught up in their new life and not get the mental health care that they need. When students arrive on campus, they may confront new challenges to adjusting to hectic schedules, making new friends, and keeping up with academic expectations, which can compound feelings of stress and despair.

The social isolation of the pandemic left students unprepared for the social transition to college and less likely to establish connections with peers and mentors at school. These forces are compounded for students entering college with a mental health condition.

Without supports in place, these students care can and often does lapse just when they need it the most. The task of navigating a switch to telehealth or finding a new provider in college largely falls on the students, and if available, their parents.

Students are left to maneuver the complexities of the health care system, including insurance coverage. With a shortage of providers in most areas and many not covered by insurance, finding an affordable and timely care can be very onerous.

Data shows that when college students don't get the mental health care that they need, it can lead to major disruptions in their education, as unaddressed mental health needs are associated with poorer academic performance and lower rates of degree completion.

In a survey conducted in 2021, over 70 percent of bachelor's and associate degree students who had considered taking a break from school in the past 6 months said emotional stress was an important reason.

In order to set students up for success in college, early identification of mental health needs and ready access to treatment are, of course, critical. When students move away from home and transition to college and adult life, continuity of care and reasonable accommodations help them manage new stressors and lead—new stressors and lead meaningful, productive lives.

That kind of support shouldn't be a luxury for students experiencing mental health conditions, but today, unfortunately, it is. Families are getting priced out of timely mental health care and the evaluations needed for mental health accommodations can cost thousands of dollars out-of-pocket.

Because of gaps in our pediatric mental health care system, many needs are not being addressed until far too late, if at all. Accessing timely mental health care that is covered by insurance shouldn't feel like winning the lottery. It should be the same as getting care for any other health condition.

That is why Ranking Member Cassidy and I introduced the Health Care Capacity for Pediatric Mental Health Act, which would establish grant programs to expand mental health integration, workforce training, and care capacity among providers to treat young people.

Senator Cassidy and I also introduced the RISE Act, which would provide information to students with mental health disabilities and their families to help them select the right college and streamline disability documentation requirements so that the cost of repetitive testing is not a barrier to reasonable accommodations.

In addition, Senator Portman and I introduced the Investing in Kids Mental Health Now Act, which would provide guidance to states on expanding pediatric mental health care capacity, and a Medicaid payment increase for pediatric behavioral health services to strengthen the continuum of care for many children.

While we have made strides this Congress to address the mental health crisis among our youngest Americans, it is clear that more work needs to be done. When pediatric emergency departments across the country are overwhelmed with children in need of mental health care, it is a cry for help.

Young people experiencing mental health challenges need somewhere to go and get the care they really need in a supportive environment where they can thrive. So I look forward to hearing from today's witnesses about how we can expand mental health support in preparation for and in the transition to college.

I will now turn to Ranking Member Cassidy for his opening statement.

OPENING STATEMENT OF SENATOR CASSIDY

Senator CASSIDY. Somewhere there is a teenager who will one day be sitting in that chair, in this chair, and be speaking of ranking members and chairs and be sitting on the dais, and she or he is our future leader.

Our obligation to that person is how do we best equip she or he in order to be the person sitting there are sitting here? And of course, I hope they are all Republicans, but maybe you can only hope for so much. And so we have to take that within the context of what we are currently addressing.

The context which we are currently addressing is that 3 years of COVID have just had their toll upon the mental health of adolescents and college students. The isolation that formerly was kind of never there because you were always with others, under COVID it became so pronounced that those who had issues could not convey them to others, but rather kept them within themselves, and we see, if you will, despair.

Now, the studies—the statistics bear out the intuition. Suicide, third leading cause of death among those 15 to 24 in 2021. Mental

health emergency room visits increased 25 percent in children, 30 percent in teens in 2020. And I go back, this is more than a statistic, it is our future. So the question is, how do we care for those teens who are our future?

Now, several people on the dais here, we have worked together. We need to reauthorize the Mental Health Reform Reauthorization Act of 2022, which Senator Murphy and I worked back on in 2016, and we need to reauthorize it. It expired in September.

There is an urgency here that we need to accomplish. I will point out, since this law passed, all 50 states now have wraparound, coordinated specialty care for teens with early psychosis.

Previewing my question for Dr. Weiss will be, why has the reach been so limited? When we put this in, we wished to have those wraparound services so that when the young person has his first psychotic episode at 16, it is his last psychotic episode because everything he needs to return him to wholeness is wrapped around and it becomes a distant memory, but not a life defining event.

We need to ensure that would occur. We also, as my co-sponsor of the legislation, Senator Casey spoke out, need to help with that transition to college from high school. And again, the Mental Health Reform Reauthorization Act of 2022 can help achieve this.

Now, we have had success on, aside from the bill I just talked about, recent success addressing mental health issues. In response to the Uvalde shooting, there are resources that are put in that response bill, which are for troubled youth at risk of suicide, at risk of addiction, of harming others, and other mental health issues that would be in high schools.

We have increased access to mental health and crisis intervention services, telemental health and in-school mental health services. I would just echo what Senator Casey just said, two bills that we put forward, Health Care Capacity for Pediatric Mental Health Act, to increase mental health access outside of hospitals so children can stay at home and don't miss school.

The RISE Act. A child will get an IEP in a high school, say, for example, for dyslexia. Then they got to get them redone when they go to college. The underlying problem leading to the IEP has not changed.

Why are we putting this obstacle as they transition from high school to college? Oh, you got to go through it again. If the condition is not permanent, that can be indicated. But usually, for example, with dyslexia, the condition is permanent.

Why do we put obstacles for people to receive the interventions they need as they are on their pathway to be filling these halls to be our future leaders. Now, it is so wonderful you see young people stepping forward.

Ms. Williams, thank you for your example that we will hear of how you have used grief in your life in order to lead people your age to mental health wholeness. An example from my own state, Emma Benoit, who attempted suicide, but after coming out of that, has used her experience and the kind of the process of events that led her to that terrible state to help others, to help her peers avoid it.

That is the way our democracy works, in which it is not just the folks on this dais helping those younger people who are our future leaders, but those younger people providing leadership in and of themselves, so they help prepare themselves to be our future leader.

With that, I yield.

The CHAIRMAN. Thank you, Ranking Member Cassidy. Now we will turn to our witness introductions. I will provide several and Ranking Member Cassidy will provide some as well. Our first witness is Dr. Sharon Hoover.

Dr. Hoover is a licensed clinical psychologist and professor at the University of Maryland School of Medicine, Division of Child and Adult Psychiatry. Dr. Hoover is also the co-director of the National Center for School Mental Health and the Director of the National Child Traumatic Stress Network's Center for Safe, Supportive Schools.

We want to thank Dr. Hoover for being here. Maybe hadn't had to travel as long as some of the others. We are grateful she could be with us to bring her expertise. For our second and third witnesses, I will turn to Ranking Member Cassidy.

Senator CASSIDY. I get to introduce two people today, two folks from Louisiana. I will begin with Dr. Curtis Wright. Dr. Wright is a Vice President for Student Affairs at Xavier University in New Orleans. He oversees numerous programs dedicated to improving student life, including education, wellness, campus safety, and athletics.

Before joining Xavier, Dr. Wright served as the Dean of Campus Life at Wagner College in New York City, and oversaw multicultural affairs at New York University, and in residence education at the University of Arkansas at Little Rock.

Dr. Wright earned his B.A. in Sociology, a Master's of Education in Adult Education from the University of Arkansas, and a Doctorate in Higher Education Management from the University of Pennsylvania. Dr. Wright's experience will allow him to speak with a wealth of knowledge and experience to us. Thank you.

Dr. Ashley Weiss. Dr. Weiss is an Associate Professor of Psychiatry and the Director of Medical Student Education and Psychiatry at Tulane University School of Medicine. She received her Bachelor of Science at Loyola University in New Orleans, and a Master of Public Health at Tulane.

Attended medical school at Lake Erie College of Osteopathic Medicine in Florida, returned to New Orleans to do a Residency in Psychiatry and Subspecialty Fellowship in Child and Adolescent Psychiatry at Tulane.

After developing expertise and caring for the young person's mental health during her medical training, Dr. Weiss built the first comprehensive first episode psychosis care program in New Orleans called Epic NOLA.

She also launched Calm, which is a community education campaign to increase people in Louisiana's awareness about emerging psychosis symptoms and available treatment. In my medical prac-

tice, I worked in the same setting as Dr. Weiss, taking care of the uninsured and the chronically mentally ill.

They would have, I tell you, benefited from your expertise, Dr. Weiss, so I am grateful that you are here, and we look forward to hearing how your experience and your education can improve the support for our youth. Mr. Casey.

The CHAIRMAN. Thank you, Ranking Member Cassidy. Our final witnesses, Ms. Brooklyn Williams. Brooklyn is a high school senior at Baldwin High School in Pittsburgh, Pennsylvania, where she has founded the Chill Club, an offshoot of the Allegheny Health Network's Chill Project.

The Chill Club is an open door mindfulness club aimed at supporting students coping with the stresses and anxieties of high school. Brooklyn, we are very pleased to welcome you here today.

We will turn to our witnesses for their opening statements. We will begin with Dr. Hoover.

STATEMENT OF SHARON HOOVER, PH.D., PROFESSOR OF PSYCHIATRY AND CO-DIRECTOR OF THE NATIONAL CENTER FOR SCHOOL MENTAL HEALTH, UNIVERSITY OF MARYLAND SCHOOL OF MEDICINE, BALTIMORE, MD

Dr. HOOVER. Good morning, thank you. I want to express my thanks to you, Chairman Casey, Ranking Member Cassidy, and to all the Members of the Subcommittee for inviting me here to speak with you about these important issues, and for your commitment to the mental health and well-being of our young people.

Again, my name is Sharon Hoover, and I will be speaking to you today from my perspective as a Professor of Child and Adolescent Psychiatry and also the co-Director of the National Center for School Mental Health and the National Center for Safe, Supportive Schools, both funded by the U.S. Department of Health and Human Services.

I also speak to you through my lens as a parent of three young people, a 9th grader, an 11th grader, and a freshman in college, so these issues are near and dear to my own heart. We are all concerned about the growing mental health needs of our young people.

The good news is that there are many strategies and effective programs to support and promote youth mental health and to also support their effective transition from high school to college. And I hope we can get into some of those programs today. I am going to share three important ideas with you this morning.

No. 1, invest early in nurturing environments for families and schools. We have incontrovertible evidence that the vast majority of challenges impacting our adolescents and young adults could be prevented by diminishing, or diminished rather by creating nurturing environment, starting early, and continuing into middle school and high school and beyond.

In Dr. Anthony Bacon's book, The Nurture Effect, he details decades of scientific research into actionable steps to reduce youth problems and to produce caring—to reduce youth problems rather, and to produce caring and productive young people.

Just as we were able to reduce the prevalence of smoking decades ago with a national public health movement, at this point in time, we need a relentless public health movement to increase the prevalence of nurturing environments that minimize toxic conditions and promote pro-social behavior in our young people.

In the earliest years of children's development, effective family interventions include things like the incredible years, nurse family partnerships, the triple-p parenting program, which exist in many of the states across our Nation but are not really at full scale as they should be. In elementary years and beyond, interventions like Family Checkup are helpful to support parents as they handle some of the common problems of their children, as they use reinforcement to promote pro-social behavior, as they monitor their children's behavior and help set limits, and as they improve family communication and problem solving.

Students who receive the family checkup program in sixth grade are much less likely to be depressed, to use substances, and to actually graduate from high school, and to not be arrested by the time they are 18.

Schoolwide systems to minimize punitive interactions and to teach and promote and ritually reinforce pro-social behaviors, and these include programs like the good behavior game, like positive behavior interventions and supports, where we have decades of research, have demonstrated long term positive impacts on adolescent risk behavior and engagement in college and career.

First, to optimize the success of our high school and college students, we must invest in nurturing environments at every level of their development. No. 2, establish comprehensive school mental health systems in all schools.

This includes supporting the mental health of all students in their classrooms through teaching social and emotional skills and mental health literacy schoolwide, and providing mental health interventions where they are, in partnership with families in schools.

Comprehensive school mental health systems not only improve mental health outcomes for our young people, but they also have, again, demonstrated success in improving really important academic indicators like attendance and grades.

In my written testimony, I provide specific examples of policies to advance mental health in schools, such as establishing mental health as a state required component of K through 12 education, like those we see in New York and Virginia, and requiring health plans to reimburse for mental health screenings that are conducted on campus.

The Hopeful Futures campaign this year released school mental health report cards across all 50 states and an accompanying legislative guide, and this is a great starting point for policymakers who wish to strengthen school mental health in their own communities, and it is detailed in my written testimony.

No. 3, we must equip high school to college transition skills for all of our students, like self-determination, time management, emo-

tion regulation, help seeking and navigating adversity. And again, we have evidence based strategies to do all of these.

This should begin by middle school and extend into college and include efforts like self-guided modules to support emotional health, free well-being screenings at high school and college campuses, peer to peer mental health education and support, and texting warm lines where students can report concerns about themselves or others.

For youth with mental health challenges, we need to provide tailored transition supports for in-person centered planning. And two such exemplary programs include the Renew Program which was developed and studied out of the University of New Hampshire, and a program called Got Transitioned, developed by the National Alliance to Advance Adolescent Health.

I want to thank you again for the time to speak. I look forward to hearing from my fellow panelists and to our further discussion.

[The prepared statement of Dr. Hoover follows:]

PREPARED STATEMENT OF SHARON HOOVER

I want to express my thanks to you, Chairman Casey, and Ranking Member Cassidy, and to all Members of the Subcommittee, for the invitation to speak with you today and for your commitment to supporting the mental health and well-being of our Nation's youth. It is a privilege to be here with you today to discuss these important issues.

My name is Sharon Hoover, and I am speaking to you from my perspective as a Professor of Child and Adolescent Psychiatry at the University of Maryland School of Medicine. I am the Co-Director of the National Center for School Mental Health and Director of the National Center for Safe Supportive Schools, both funded by the US Department of Health and Human Services. I also speak to you through my lens as a parent to three teenagers, 9th and 11th graders in high school, and a freshman in college. So, my remarks are informed by my 25 years of working with children, adolescents, and their families and schools, and are also personally meaningful to me as someone who is navigating the high school and college years of our own children.

Youth Mental Health Needs are Urgent and Rising

We are all concerned about the growing mental health challenges among our children and adolescents.

This year, U.S. Surgeon General Vivek Murthy as well as some of our most valued child-serving national institutions including the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, and the Children's Hospital Association have highlighted the urgency of youth mental health needs.[1, 2]

Youth mental health has worsened over the past decade, and this has only been exacerbated during the pandemic,[3] with increased rates of anxiety and depression symptoms and positive suicide risk screens among youth.[4, 5]

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[1] Office of the Surgeon General. (2021). Protecting Youth Mental Health: The U.S. Surgeon General's Advisory. U.S. Department of Health and Human Services. Washington, DC.

[2] American Academy of Pediatrics. (2021, October 19). AAP-AACAP-CHA Declaration of a National Emergency in Child and Adolescent Mental Health. *https://www.aap.org/en/advocacy/child-and-adolescent-healthy-mental-development/aap-aacap-cha-declaration-of-a-national-emergency-in-child-and-adolescent-mental-health/*.

[3] Centers for Disease Control and Prevention. (2020). Youth Risk Behavior Surveillance Data Summary & Trends Report: 2009–2019. *https://www.cdc.gov/nchhstp/dear-colleague/2020/dcl-102320-YRBS2009-2019-report.html*.

[4] Mayne, S. L., Hannan, C., Davis, M., Young, J. F., Kelly, M. K., Powell, M., Dalembert, G., McPeak, K.E., Jenssen, B.P., & Fiks, A.G., (2021). COVID–19 and adolescent depression and suicide risk screening outcomes. Pediatrics, 148(3), e2021051507. *https://publications.aap.org/pediatrics/article/148/3/e2021051507/179708/COVID-19-andAdolescent-Depression-and-Suicide*.

[5] Lantos, J. D., Yeh, H-W., Raza, F., Connelly, M., Goggin, K., & Sullivant, S. A. (2022). Suicide risk in adolescents during the COVID–19 pandemic. Pediatrics, 149(2), e2021053486.

Many youth lack the fundamental skills and supports necessary to transition from high school to college and career.

The good news is that there are many best practices and strategies to promote student mental health and successful transition.

As you consider opportunities to promote the well-being of our youth and set them on a path to successful college and career, I will share *three important ideas* for you to consider:

(1) Invest Early in Nurturing Environments in Families and Schools.

Especially in the wake of the pandemic, young people have not had adequate exposure to well-being promotion. Ask kindergarten and first grade teachers right now and they will tell you that their students are not adequately learning and demonstrating the critical social, emotional, and behavioral skills that will help them to succeed at home and in school and eventually in career and college. These need to be taught both at home and in school.

I recognize that we are here today talking about high school and college students. However, I would argue that the environment of our youngest learners is what will foster or hinder their ultimate success at this critical transition. The data would back me up.

We have incontrovertible evidence at our fingertips that the vast majority of challenges impacting our adolescents and young adults, those transitioning from high school to college, could be prevented or diminished by creating nurturing environments starting early and continuing into middle and high school and beyond.

If I can urge you to add one book to your bookshelf today, it would be "The Nurture Effect: How the Science of Human Behavior Can Improve Our Lives and Our World" by Dr. Anthony Biglan.[6] Dr. Biglan is a Senior Scientist at the Oregon Research Institute and has been conducting research on the development and prevention of child and adolescent problem behavior for the past 30 years.

This book distills down decades of scientific research from our fields of psychology and prevention science into tangible, actionable steps that policymakers, families, and institutions like schools can take to reduce youth problems and to produce caring and productive young people.

In a nutshell, the research from years of rigorous randomized trials tells us that all successful interventions make environments more nurturing in at least three of four ways:

- Promoting and reinforcing prosocial behavior
- Minimizing socially and biologically toxic conditions, like poor nutrition and housing insecurity
- Monitoring and setting limits on influences and opportunities to engage in problem behavior
- Promoting the mindful, flexible, and pragmatic pursuit of prosocial values

These interventions can and should be implemented with both families and schools.

In the earliest years of children's development, effective interventions include things like *Incredible Years, Nurse-Family Partnerships, and the Triple P Parenting Program*. In elementary years and beyond, interventions like *Family Check Up* are helpful to support parents in handling common problems, using reinforcement to promote positive behavior, monitoring their child's behavior and setting limits, and improving family communication and problem solving. In a randomized trial of this program in middle schools in Oregon, the program significantly increased parents' monitoring and reduced family conflict. Even more striking is that although this program was implemented in 6th grade, those young people who received the program were less likely to use alcohol, tobacco, or marijuana and less likely to be arrested when they were 18 years old.

Schoolwide systems to minimize coercive and punitive interactions and to teach, promote, and richly reinforce prosocial behaviors have demonstrated long-term positive impacts on adolescent risk behavior and engagement in college and career. When implemented with fidelity, the promise of programs like *Good Behavior Game,*

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https://publications.aap.org/pediatrics/article/149/2/e2021053486/184349/Suicide-Risk-inAdolescents-During-the-COVID-19.

[6] Biglan, A. (2015). *The nurture effect: How the science of human behavior can improve our lives and our world*. New Harbinger Publications.

Positive Action, and *Positive Behavioral Interventions and Supports* to promote prosocial outcomes in our adolescents and young adults is tremendous.

An ounce of prevention is worth a pound of cure. Every time you move to invest in downstream interventions, first consider the root causes and reallocate investment upstream.

(2) Establish Comprehensive School Mental Health Systems in all Schools

Increasingly, schools have *comprehensive school mental health systems*, reflecting partnerships between the education and behavioral health sectors to support a full continuum of mental health supports and services, from promotion to treatment.[7] These school-based mental health supports improve vital academic indicators, including attendance, grades, and test scores.[8] Every child deserves to have this type of mental health support in their school.

Below, I provide specific examples of policies to promote universal mental health promotion for all students and to expand early identification and intervention services in schools.

Policies to Support Universal Mental Health Promotion and Prevention Policies

- **Require the selection of indicators of student mental health and well-being** as a core metric of school performance under federal education funding, with provisions to assist schools as they strive to perform well on these indicators. Indicators may include school climate, student-reported subjective well-being and distress, and reports of school connectedness.
- **Incentivize teaching education programs to include mental health literacy** to improve the capacity of the educator workforce to: promote mental health of all students in the classroom, including teaching of social-emotional learning competencies; identify mental health concerns and link students to needed supports and services; reduce stigma related to mental illness; and promote student and family help-seeking.
- **Establish mental health as a state-required component of K-12 curricula**, with efforts in New York and Virginia as examples. The federal government could support this state-level effort by passing a resolution encouraging states to follow existing state efforts to integrate mental health into curricula and by providing direct funding for educator training and ongoing professional development.
- **Leverage Federal Title I and Title IV funding to provide universal mental health programming for students**, including social-emotional learning programming. Joint guidance by the U.S. Department of Education and the U.S. Department of Health and Human Services could support states as they navigate these funding mechanisms to support universal mental health in schools.
- **Expand federal grants to state and local education and behavioral health authorities to increase mental health awareness and promotion in schools**. This could include the expansion of grant programming initiated in recent years by SAMHSA (e.g., Project AWARE) and the U.S. Department of Education (School Climate Transformation) that require funded states to partner with three local jurisdictions to promote student well-being and mental health training and awareness for school staff, and then to scale successful efforts statewide.

Policies to Support Early Identification, Intervention, and Treatment in Schools

- **Expand existing federal workforce development programs** (e.g., Behavioral Health Workforce Education and Training Program, National Health Service Corps, Minority Fellowship Program) to increase the

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[7] Hoover, S. A., Lever, N. A., Sachdev, N., Bravo, N., Schlitt, J. J., Price, O. A., . . . & Cashman, J. (2019). *Advancing Comprehensive School Mental Health Systems: Guidance from the Field*. National Center for School Mental Health, University of Maryland School of Medicine.

[8] Kase C, Hoover S, Boyd G, et al: Educational outcomes associated with school behavioral health interventions: a review of the literature. J Sch Health 2017; 87:554–562.

school mental health workforce. This strategy can also be applied to federal loan repayment programs by increasing incentives for providers who choose schools as a service setting.

- **Expand federal, state, and local funding to ensure adequate staffing and professional development for student instructional support personnel**, including school psychologists, school social workers, school counselors and school nurses. Funding expansion could include increased investments in Title I of the Every Student Succeeds Act (ESSA) to provide additional mental health staffing for students living in poverty and in Title I, Title II, and Title IV of ESSA and IDEA to increase opportunities for professional development. State and local investments could include competitive salary and benefits packages to recruit and retain school mental health providers and supplementing federal funding for staffing and professional development.
- **Strengthen and support funding for mental health services by investing in school Medicaid programs**. Ensure states and school districts are fully participating in school Medicaid by modernizing existing guidance for schools to provide clarity and best practices in school Medicaid, including those that address mental health prevention and early intervention.
- **Require health plans to reimburse for mental health screenings conducted in schools**. Follow guidance from the American Academy of Pediatrics and the American Academy of Child and Adolescent Psychiatry to cover universal mental health screening as a mechanism for improving mental health and reducing mental illness. Coverage should include screening conducted during well-child exams in pediatric primary care, and also extended screening conducted in schools.
- **Maximize Medicaid, Children's Health Insurance Program (CHIP) and private reimbursement for school mental health services**, including early identification, intervention, and treatment. This may include better understanding and leveraging existing state Medicaid allowances for school mental health or the initiation of state plan amendments to improve school mental health coverage. As outlined in the 2019 Joint Informational Bulletin from The Centers for Medicaid and Medicare Services (CMS) and SAMHSA, several states already access Medicaid and other payers, including private insurers, to cover school and community professionals' delivery of mental health services in schools. The Centers for Medicaid and Medicare Services (CMS), the U.S. Department of Education and the U.S. Department of Health and Human Services could offer technical assistance to states seeking to improve Medicaid and other payer coverage of school mental health.
- **Expand reimbursement and technical assistance for telemental health services in schools**. Given the current national shortage of mental health specialists, particularly in rural settings, schools will benefit from access to telemental health consultation and direct service, facilitated by public and private insurance coverage and federal- and state-supported technical assistance.
- **Implement accountability mechanisms that require the implementation of high-quality, evidence-based practices that align with national performance standards for school mental health**. Federal, state, and local investments should shift their metrics away from counting frequency and duration of services to measuring the implementation of national best practices for school mental health care and impacts of school mental health services provision on psychosocial and academic outcomes (see *www.theSHAPEsystem.com*).

The *Hopeful Futures Campaign*, a coalition of national organizations committed to ensuring that every student has access to effective and supportive school mental health care, released this year the first ever "America's School Mental Health Report Card and Action Center," with *individual report cards* for all 50 states and the District of Columbia. These school mental health report cards highlight accomplishments and provide important action steps to help address the children's mental health crisis in every state. They serve as a great starting point for policymakers who want to strengthen school mental health supports and policies in their communities. I also urge you to review The Hopeful Futures Campaign *School Mental*

Health Legislative Guide released just a few weeks ago.[9] This guide offers exemplar legislation across eight key dimensions of school mental health (detailed below) and can serve as a roadmap for states and Federal policymakers to advance school mental health.

School Mental Health Legislative Guide Recommendations and Examples

1. School Mental Health Professionals—We urge states to meet nationally recommended ratios for school psychologists, counselors, and social workers, and to ensure that these providers reflect the diversity of the students they serve. We also urge you to consider how to broaden your workforce beyond these specialists to include peer supports, community health workers, and bachelors level professionals that can receive a certificate in youth mental health.

Delaware and Arizona both passed bills to implement a process of reaching national ratios for school counselors and psychologists or licensed mental health professionals.

Alabama requires each local board of education to establish a school mental health service coordinator.

2. Teacher and Staff Training—Regular training in mental health, substance use, and suicide prevention can help educators and staff feel better equipped to identify warning signs of mental health or substance use problems, to respond appropriately, and to have knowledge of available resources and effective interventions. While many states have training in one or more of these topics, few states specifically require all three topics.

North Dakota is notable for requiring a minimum of eight hours of youth behavioral health training every two years for teachers and staff, and specifying a range of topics, including trauma, resiliency, suicide prevention, bullying, understanding of the prevalence and impact of youth behavioral health wellness, behavioral health symptoms and risks, referral sources and evidenced-based interventions, strategies to reduce risk factors, and evidence-based behavior prevention or mitigation techniques.

3. Funding Supports—Sustainable funding for school mental health services is critical and Medicaid can play an important role, bringing federal matching funds that help state dollars go further. Multiple state Medicaid programs cover school mental health services, including via telehealth, for all Medicaid-enrolled students, but many others limit coverage to students on an Individualized Education Programs (IEP). Some states have taken the additional step of ensuring that all school mental health professionals are eligible to bill under their state's Medicaid program.

Michigan has taken a further step by also including certified school psychologists and licensed school social workers as Medicaid-billable providers.

4. Well-Being Checks—Regular checks of mental wellness can help identify students and staff who may need support. With high rates of trauma, anxiety, depression, and other mental health and substance use challenges, it's important to be able to intervene early and provide the services and supports.

New Jersey stands out for taking a step in the right direction on well-being checks. In 2021, New Jersey created a $1 million Mental Health Screening in Schools Grant Program that provides funds for schools to administer annual depression screenings for students in grades 7–12.

Illinois followed suit by recently Establishing the Wellness Checks in Schools Collaborative for school districts that wish to implement wellness checks to identify students in grades 7 through 12 who are at risk of mental health conditions.

5. Healthy School Climate—This involves policies that foster safe, supportive schools help create a positive learning environment and foster mental wellness for all students, but especially for LGBTQ students, students of color, and other highly impacted populations.

As of last year, Arkansas Requires every school district to conduct a school safety audit every three years, including an audit of the school climate and culture.

In 2019, Utah passed legislation that Requires creating a model school climate survey that may be used by a local education agency to assess stakeholder perception of a school environment.

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[9] Hopeful Futures Campaign. State legislative guide for school mental health. August 2022. *https://hopefulfutures.us/wp-content/uploads/2022/09/State-Legislative-Guide-for-School-Mental-Health-1.pdf.*

6. Skills for Life Success—Life skills competencies, such as developing healthy relationships, responsible decision-making, and self-management, can help students at every age succeed in school and life. Washington State has gone the extra mile to support students in gaining age-appropriate K–12 life skills through multiple statutes.

Many states have taken promising steps by adopting life skills competencies in K–12 but have yet to establish them in statute. One example is Arkansas, which offers the G.U.I.D.E. for Life program, which is designed to help K–12 students develop skills in growth (manage yourself), understanding (know yourself), interaction (build relationships), decisions (make responsible choices), and empathy (be aware of others).

7. Mental Health Education—Mental health education, when well-implemented and fully integrated into K–12 health education, can increase awareness and understanding and promote help-seeking behavior. While many states mention mental health concepts in their health education, states are increasingly passing legislation to ensure comprehensive, age-appropriate mental health education in every grade.

New York deserves continued praise for its widely lauded mental health education law, which requires that all schools' health education programs include mental health.

Utah just passed legislation that Requires the Huntsman Mental Health Institute and the State Board of Education to coordinate to develop a youth mental health curriculum in schools.

I love that Utah was intentional about not only sharing this curriculum with schools, but also with parents and families and other youth-serving organizations so that we can all be in this together.

8. School-Family-Community Partnerships—Partnering with and effectively engaging families, youth, and community stakeholders, including community-based mental health providers, is vital to successfully implementing and sustaining a comprehensive school mental health system.
Youth Behavioral Health Initiative with multiple requirements, including competitive grants to support school-linked behavioral health services for children and youth 25 years of age and younger. The bill also requires health insurance plans to cover mental health and substance use disorder treatment delivered at schools.
Support Partnerships to fund community partnerships to meet students' behavioral health needs, to ensure partnerships provide services in a holistic and non-stigmatized manner and coordinate with youth-serving government agencies, and to develop a model for expanding school behavioral health services and maximize Medicaid and private insurance participation.

3. Equip Students With High School-to-College Transition Skills Using Evidence-Based Strategies

In addition to providing early nurturing environments at home and in school and installing comprehensive school mental health systems in every school in the Nation, we can invest in evidence-based programming to equip our students with transition skills like self-determination, time management, emotion regulation, and coping with adversity.

This programming can begin in high school and extend into college, and can be fostered at home and in school, including through self-guided modules.

Examples of Programs to Support High Schooler Mental Health as They Prepare for College and Career

- **Postsecondary Resilience Education Program (PREP)** is designed to help ease the transition to college. In this course, students master the skills needed to reach their academic goals. The structure of PREP lets students access the content in any order and to any depth, so they can focus on the skills that they would most benefit from mastering.
- **Student Curriculum on Resilience Education (SCoRE)**—Self-Paced helps students cope with the personal, social, and academic challenges of college life and prepare for future success. This online course can be purchased by individual students or offered by colleges and universities as part of a counseling program, first-year experience curriculum, wellness program, or student retention initiative.

- The JED Foundation (nonprofit that protects emotional health and prevents suicide for our nation's teens and young adults):
  - ″**Set to Go**″—information and resources specific to the transition from high school to college
  - **The Transition of Care Guide**, provides a detailed steps for students and families to take during each year in high school and in college in order to transition their care. Major steps outlined: learn the details of your condition and treatment; discuss, discover, and define your personal needs to find the best college for you; manage the transition of care
- **NAMI Mental Health College Guide** (developed in collaboration with the JED Foundation). Provides guidance about transition from high school to college focused on relationships and self-care; self-advocacy, HIPAA & FERPA; mental health, identity, race; taking care of your mental health; staying safe.
- **Guidance from American Academy of Child and Adolescent Psychiatry** Provides guidance for students with mental health challenges and their families on considerations for colleges (e.g., mental health supports on the campus, developing expectations about academic workload etc.)

Examples of Programs to Support College Student Well-Being and Mental Health

- **Free mental health screenings**. Drexel University's Recreation Center has a mental health screening kiosk. Students can complete a private, short mental health screening. At the end of the screening, students receive information for mental health resources and supports, if needed. The work is a product of collaboration between Drexel, the *Thomas Scattergood Foundation*, a local grant-making organization; *Screening for Mental Health, Inc.*, a nonprofit geared toward large-scale mental health screenings; and the *Philadelphia Department of Behavioral Health and Intellectual disAbility Services*.
- **Developing and fostering resilience**. Florida State University launched an online trauma resilience training tool developed through the Institute of Family Violence Studies and their College of Social Work. The Student Resilience Project developers recognized that many students coming to their university have experienced "significant family and community stress" and that stress can affect their learning. Florida State University now requires all incoming freshmen and transfer students to participate in the training, which features videos, animations, and TED-talk-style informational sessions to foster student strengths and coping strategies. Student Resilience Project: *https://strong.fsu.edu/*.
- **Encouraging talking about mental health (personal challenges and talking with peers)**.
  - Kognito Program. At least 350 colleges use Kognito's "HigherEd Mental Health Suite" that "prepares learners to lead real-life conversations around mental health and suicide prevention that build resilience, a strong campus culture and strengthens relationships." Kognito Mental Health Suite: *https://kognito.com/mental-health-suite/*
- **Texting programs**. University of Sioux Falls—one of the first universities to offer free texting hotline for students called Text4Hope. Aims to guide students who are concerned about a peer or about themselves. *https://mentalhealthfoundation.ca/text4hope/*
- **Peer-to-peer approaches**.
  - Active Minds is a national organization supporting mental health awareness and education for young adults. Hundreds of college campus chapters across the country. Active Minds changes the conversation about mental health among adolescents and young adults, reduces stigma associated with mental health conditions, and establishes a culture of caring on college and university campuses. Programs and resources are built for students, faculty, staff, administrators, and the broad campus community to ensure long-term change at the individual, campus community, and policy levels. Active Minds prioritizes the student voice to ensure a student-driven and student-focused approach in mental health promotion. We inspire mental health advocates to have conversations that have the

potential to save lives. Link to information for specific higher ed programming here: *https://www.activeminds.org/programs/colleges-universities/*

- UVA Project RISE is a peer counseling service that was established in 2006 by a small group of Black students. It is a university-sponsored program that provides free, one-on-one, confidential services to enrolled University of Virginia students. Program directly connected through both the Office of African American Affairs and to the department of Counseling and Psychological Services in Elson Student Health More information here: *https://oaaa.virginia.edu/project-rise*

- **Training/resources for university faculty and staff**.
  - University of North Carolina recently trained 900 faculty and staff in *Mental Health First Aid*—aimed to provide basic skills to support students with mental health and substance use challenges
  - Penn State *"Red Folder Campaign"*—guides faculty, staff, student leaders, and others who are interacting with students to recognize, respond effectively to, and refer Penn State Students in various states of distress (high, moderate, low)
- **Rapid access to support**.
  - **Let's Talk Programs**. Many universities across the country use "Let's Talk" programs to facilitate rapid access to support. Let's Talk encourages informal one-on-one sessions with a university counselor. Many universities offer tele options.
- **College orientation**. More colleges beginning to share mental health information with students during orientation sessions. Approaches to these sessions include traditional presentations and panel discussions, role plays, short videos, and student testimonials. Goal of these sessions is for students to understand how to recognize signs of mental health challenges, know where to access resources and supports, and learn how to talk with friends who might be struggling with their mental health. Example from Northwestern University: Originally, mental health orientation sessions included information provided by expert speakers. Based on feedback from students, orientation organizers shifted to student testimonials that included narratives of alumni sharing their mental health challenges and how they received help.

In addition to programming for all students to navigate the high school-to-college transition, it is important to invest in tailored supports for students at risk for or with mental health needs. There is good evidence that providing person-centered planning and transition support for students with specific health care needs, including mental health, can significantly improve the probability of a successful transition to college and career.

As one example, colleagues at the University of New Hampshire demonstrated the success of the *RENEW program* to promote college and career readiness for students with significant emotional and behavioral disorders.

Similarly, the National Alliance to Advance Adolescent Health developed the *Got Transition* program to facilitate the health care transition of youth with special health care needs from pediatric to adult health care.

Colleagues at the University of Washington have demonstrated the success of weaving mental health education and support into a *comprehensive college preparation program* that supports vulnerable youth from middle school through successful college graduation.

I want to express my gratitude to you all for opening up this important discussion and I look forward to hearing from my fellow panelists and engaging in discussion with you all.

The CHAIRMAN. Thank you, Dr. Hoover.

Now we will turn to Dr. Wright.

STATEMENT OF CURTIS WRIGHT, ED.D., VICE PRESIDENT OF STUDENT AFFAIRS, XAVIER UNIVERSITY OF LOUISIANA, NEW ORLEANS, LA

Dr. WRIGHT. Subcommittee Chair Casey, Subcommittee Ranking Member Cassidy, and the Members of the Committee on Health, Education, Labor, and Pensions Subcommittee on Children and Families, thank you for the opportunity to testify today.

It is an honor and privilege to sit before you this morning as the Vice President for Student Affairs and Interim Vice President for Enrollment Management at Xavier University of Louisiana, the Nation's only Black and Catholic institution of higher education.

I was asked to testify this morning to address the importance of strengthening the continuum of mental health support for all adolescents, particularly in the years leading up to and during the transition to college. I will do that, and of course, I will also offer a particular lens which allows me to address the issues confronted by those students who choose to matriculate at HBCUs.

Chairman Casey, most students who entered Xavier University in August have never known a world without Facebook or war. While I learned how to exit the building in a single file line in preparation for a potential fire, my students have learned how to run, hide, or fight their ways out of an active shooter situation.

They are all too familiar with social, political, and racial unrest in this country, and they have probably participated in more marches or rallies than most of us in this room. They have lived through global economic recessions that resulted in family members losing their jobs, homes, and overall financial instability.

They are also still in the midst of a global pandemic that caused the entire world to stand still and reimagine what normal looks like. Some of these young people lost multiple family members due to COVID related illness, in part because they lacked access to affordable health care, and also had family members whose primary source of income meant their status as a front line worker was nonnegotiable.

Our students were well acquainted with loss long before the pandemic as they routinely attended candlelight vigils, memorials, and funerals for friends who died due to gun violence, drug addiction, and suicide. What our student at Xavier experience mirrors what their peers across the country are experiencing.

The prevalence of anxiety and depression is rising across the Nation, particularly among young people. College students of all ages are more distressed than ever before, and increasing shares are enrolling with mental health histories in terms of diagnosis, treatment, and medication.

Institutions like Xavier are challenged to recreate systems of care and support to meet the growing needs of a very different student body. While students and their lived experiences they bring to campus have changed, the funds who take care of them have not.

The number of students seeking help at campus counseling centers have increased almost 40 percent between 2009 and 2015 and continued to rise until the pandemic began. This is according to

data from Penn State University's Center for Collegiate Mental Health.

We, like so many of our peers, know that we can't do it alone and are developing strategic relationships with our K through 12 partners and our parent community. Access to health care, specifically mental health care, is not always readily available to students who come from rural areas, inner cities, or economically depressed communities.

Most colleges and universities were the direct beneficiary of the CARES Act, the HERF II of the Consolidated Appropriations Act of 2021, and HERF III authorized by the American Rescue Plan. These critical legislative lifelines allow us to maintain university life for our students throughout the pandemic.

The HBCU bond thrust of 2022 have altered the higher educational landscape for every single student studying at historically Black college to better their lives. For this specific set of institutions, not only to be singled out and threatened repeatedly, have caused our students untold mental anguish and stress.

Although the prosecution of those who maliciously caused the situation is a law enforcement issue, the impact on our students is not. Specific mental health focus should be directed to us as the sole recipients of these threats.

Senator Casey, over 20 years ago, a mentor asked me if I knew the difference between a high school senior and a college freshman. After often what I considered to be these profound responses, she replied without emotion, 3 months.

For incoming students, 3 months is the only thing for separate high school from college. Yet we believe that these students should arrive on campus fully prepared to not only make adult decisions, but more importantly, to live within those adult consequences. It is our responsibility to help them navigate the contested intersections of university life.

While the landscape as it relates to mental health with young people can appear bleak, I like my fellow Arkansan President William Jefferson Clinton still believe in a place called hope. I am hopeful because of the resilience of our students and the generation from which they have come.

However, for them to achieve success, we must dismantle our outdated systems that were not designed for their success. So, Mr. Chairman, I want to leave you with some recommendations.

First, similar to the guidance offered by the Office of Civil Rights related to Title IX, the Department of Education should consider offering guidance on mental health first aid to support educators and administrators for all K through 16 institutions which receive Federal funding.

No. 2, the Department of Education should extend the funding period for HERF I, II, and III, as well as the HBCU, TCU, and MSI set aside funding until August 31st, 2026. HELP must push the Senate to red line House Resolution 6893, IGNITE HBCU and MSI Act to improve HBCU facilities in response to the HBCU bomb threats and increase the sense of security on our campuses.

No. 4, financial stress is one of the most prevalent causes of anxiety for students entering college across the country. Congress should continue to advance common sense legislation to reduce the costs of higher education and support President Biden's plan to address college debt through limited student loan forgiveness.

Last, Congress should follow the lead of Senator Casey and the distinguished gentleman from the great State of Louisiana to Senator Cassidy and pass the Health Care Capacity Act for Pediatric Mental Health and the RISE Act. It has been an honor to present this testimony, and I thank the Committee for addressing this important issue.

As a leader in higher education, I know the benefits of early screening, the impact of developing coping strategies, and the importance of empowering families to train their children to become problem solvers.

We must address this mental health concern of our youth as the stakes have never been higher and our collective work should be a priority for every American. I am grateful to the Committee for leaning into this very difficult conversation, and Xavier University of Louisiana stands ready to serve as a resource and Committee partner.

For more information and details regarding my remarks, I ask that you read my written testimony for support for your review.

[The prepared statement of Dr. Wright follows:]

PREPARED STATEMENT OF CURTIS WRIGHT

Introduction

Subcommittee Chairman Casey, Subcommittee Ranking Member Cassidy, Committee Chair Murray, Ranking Member Burr, and Members of the U.S. Senate Committee on Health, Education, Labor, and Pension's Subcommittee on Children and Families, thank you for the opportunity to testify today.

It is an honor and privilege to sit before you this morning as the Vice President for Student Affairs and Interim Vice President for Enrollment Management at Xavier University of Louisiana. Xavier was founded by Saint Katharine Drexel of the sisters of the Blessed Sacrament and is the only institution of higher education in the country that is both Catholic and a historically Black college or university (HBCU).

Xavier's mission since 1925, in part, has been to contribute to the promotion of a more just and humane society by preparing our students to assume roles of leadership and service in a global society. We do this by cultivating a diverse learning and teaching environment that incorporates all relevant educational means—including research and community service. Our students can engage in a world class practical liberal arts curriculum while living out the mission of our university.

Before the Committee today, I will address the importance of strengthening the continuum of mental health support for all adolescents, particularly in the years leading up to and during the transition from high school to college. I will also address unique challenges of students who are first generation college students, students who come from lower socio-economic backgrounds, and those who are attending HBCUs.

Chairman Casey, most students who entered Xavier University of Louisiana in August, have never known a world without Facebook or war. While I learned how to exit the building in a single file line in preparation for a potential fire, my students have learned how to "run, hide or fight" their way out of an active shooter situation. They are all too familiar with social, political and racial unrest in this country, and they have probably participated in more marches or rallies than most of us in this room. They have lived through global economic recessions that resulted in some family members losing their jobs, homes and overall financial instability. They are also emerging from a global pandemic that caused the entire world to

stand still and reimagine what normal looks like. These young people have lost multiple family members due to COVID related illnesses, in part, because they lacked access to affordable healthcare. Additionally, for the student population we serve, the vast majority of their parents were front line workers, and because of that the members of their households have been more exposed to the coronavirus pandemic . Whether they are from Staten Island, Chicago or New Orleans, these students were well acquainted with loss, long before the pandemic as they routinely attended candlelight vigils, memorials, and funerals for friends who died due to gun violence, drug addiction, or suicide.

We, like so many of our peers, know that we cannot confront our students mental health challenges alone, and we are developing strategic relationships with our K–12 partners and our parent community. We have learned that the habits of self-care that our students bring with them are informed, in part, by their environment. Access to healthcare, specifically mental healthcare, is not always readily available to students who come from rural areas, inner cities or economically depressed communities. Most colleges and universities are the direct beneficiaries of the Coronavirus Aid, Recovery, and Economic Security (CARES) Act, Public Law 116–136; the Consolidated Appropriations Act of 2021 and its Higher Education Emergency Relief Fund II (HEERF II), Public Law 116–260; and the HEERF III which was authorized by the American Rescue Plan (ARP), Public Law 117–2. These critical legislative lifelines allowed colleges and universities, like ours, to maintain university life for our students throughout the pandemic. In fact, at Xavier, we were able to expand the reach of our Counseling and Wellness office by adding additional therapists, offering enhanced services and training our community on mental health first aid. In addition to the HEERF funding received by almost every college and university, the specific funding allotted only to HBCUs, Tribal Colleges and Universities (TCUs), and Minority Serving Institutions (MSIs) has been instrumental in the accomplishments above. We are acutely aware that the provisions of three pieces of legislation have an expiration date and are working alongside community partners to identify other resources that may fill the gaps that will be left as the funding sunsets. However, we would like the Senate HELP Committee to consider passing an extension of the funding through August 31, 2026.

Mental Health on College Campuses

What our students at Xavier experience mirrors, what their peers are experiencing across the country, even though there are some real, unique, and necessary to mention experiences recently at HBCUs. In a 2022 *Chronicle of Higher Education* article entitled, "Overwhelmed: The real campus mental-health crisis and new models for well-being", Researchers suggests the following:

> The prevalence of anxiety and depression is rising across the country, particularly among young people. College students of all ages are more distressed than ever before, and increasing shares are enrolling with mental-health histories, in terms of diagnoses, treatment, and medication." Institutions like Xavier University are challenged to recreate systems of care and support to meet the growing needs of a very different student body.

According to data cited in a 2022 article in the *Journal of Affective Disorders*, "By nearly every metric, student mental health is worsening." During the 2020–2021 school year, more than 60 percent of college students met the criteria for at least one mental health problem, according to the Healthy Minds Study, which collects data from 373 campuses nationwide (Lipson, S. K., et al., Journal of Affective Disorders, Vol. 306, 2022). In another national survey, almost three quarters of students reported moderate or severe psychological distress (National College Health Assessment, American College Health Association, 2021). While students and the lived experiences they bring to campus have evolved and changed, the funding to take good care of those students has not although the demands for that funding have increased dramatically.

Penn State's Center for Collegiate Mental Health shared, "That rising demand (for mental health care) hasn't been matched by a corresponding rise in funding, which has led to higher caseloads." nationwide, the average annual caseload for a typical full-time college counselor is about 120 students, with some centers averaging more than 300 students per counselor (CCMH Annual Report, 2021). The number of students seeking help at campus counseling centers increased almost 40 percent between 2009 and 2015 and continued to rise until the pandemic began, this is according to data from Penn State University's Center for Collegiate Mental Health (CCMH), a research-practice network of more than 700 college and university counseling centers (CCMH Annual Report, 2015).

The Xavier University Community Response

At Xavier University of Louisiana, and institutions like us, we are working across the campus to address the growing mental health challenges of our students. At Xavier specifically, we have expanded the reach of our Counseling and Wellness office by using HEERF funding to add additional therapists and mental health counselors. Relatedly we expanded offerings around campus to empower students with the tools to address commonly known stressors, which include:

- Mindfulness and Meditation
- Time Management/Study Skills/Financial Literacy Workshops
- Creating Virtual Parent Communities
- Enhanced Fitness and Wellness Options

Recognizing the need to deepen the pool of individuals prepared to respond in emergency situations, we engage in Mental Health First Aid training. These workshops provide student leaders, faculty, and staff with basic skills in identifying mental health concerns and connected them with resources to support students before a crisis arises.

One of the major projects introduced at Xavier University is the "Take A Minute RU Ok" campaign. Guided by the notions of connection, commitment and community, students, faculty and staff are encouraged to engage in intentional self-care. Through workshops, social media and random acts of kindness, the community is routinely exposed to information about how to connect to something outside of themselves, challenged to follow-through on commitments, and invited to be involved in a community that cares.

Our unfinished work requires us to build alliances with faith communities, K–12 partners, and community groups, to share resources. We know that our students come to us from communities that have not always placed value on asking for help. Central to our efforts will be exposing our students and families to resources in their communities along with the need to reduce the stigma attached to accessing mental healthcare. We are heartened by the work that lies ahead.

HBCU Bomb Threats

The HBCU bomb threats of 2022 have altered the higher education landscape for every student studying at an historically Black college to better their life. For this specific set of institutions, only, to be singled out and threatened repeatedly has caused our students—Black students already who have likely overcome significant societal pressures to find themselves on the verge of a life changing degree—untold mental anguish and stress. Although the prosecution of those who maliciously caused this situation is a law enforcement issue, the impact on our students is not. Specific mental health focus should be directed to us as the sole recipients of these threats. The Commerce, Justice, and Science (CJS) Appropriations bill for fiscal year 2023 should have language that guides the funding for National Joint Terrorism Task Force's ability to harden campuses specifically to HBCUs instead of generally extending the funds to states who do not report back to Congress which institutions receive it and likely award the funding to their "flagship institutions." Additionally, the Senate HELP Committee must pass the IGNITE HBCU and MSI Excellence Act (H.R. 6893) to improve HBCU facilities, harden the campuses to reduce the likelihood of these kinds of threats, and allow the cyber-related infrastructure to be strengthened enough to track these threats when they occur.

Commonsense Solutions

As it relates to mental health and our young people, the national landscape can appear bleak. However, I have much in common with my fellow Arkansan, President William Jefferson Clinton: *I still believe in a place called Hope*. I'm hopeful because of the resilience of our students and their generation. For them to achieve success, we must dismantle outdated systems that were not designed for their success. So, Chairman Casey and Ranking Member Cassidy, I want to leave you with some recommendations:

- Similar to guidance offered by the Office of Civil Rights related to Title IX, the Department of Education should consider offering guidance on mental health first aid to support educators and administrators for all K–16 institutions which receive Federal funding.
- The Department of Education should consider extending the funding period for the HEERF I, II, and III as well as the HBCU, TCU, and MSI

set aside funding until August 31, 2026, which will allow colleges and universities to continue to provide uninterrupted coordinated care to our students as they transition to campus.

- HELP must push the Senate to "redline" H.R. 6893, the IGNITE HBCU and MSI Act to improve HBCU facilities in response the HBCU bomb threats and increase a sense of security on the campuses. The fiscal year 2023 CJS Appropriations bill must also include guiding language to direct funding to HBCUs to harden their campuses in response to the HBCU bomb threats.
- Financial stress is one the of most prevalent causes of anxiety for students entering college across the country. Congress should continue to advance common-sense legislation to reduce the costs of higher education and support President Biden's plan to address college debt through limited student loan forgiveness.
- As previously mentioned, students arrive on campus with few coping skills as well as co-morbidities that impact their academic success. Earlier intervention would provide those students with the strategies and resources that they could equip them with tools for success. With that being said, Congress should follow the lead of Senators Casey and Cassidy and pass S. 4472 the Health Care Capacity for Pediatric Mental Health Act and S. 2550, the RISE Act.

Conclusion

It has been an honor to present this testimony. I thank the Committee for addressing this important issue. As a leader in higher education, I know the benefits of early screening, the impact of developing coping strategies, and the importance of empowering families to train their children to become problem solvers. We must address the mental health concerns of our youth as the stakes have never been higher and our collective work should be a priority of every American. I'm grateful to the Committee for leaning into this very difficult conversation and Xavier University of Louisiana stands ready to serve as a resource and community partner.

[SUMMARY STATEMENT OF CURTIS WRIGHT]

Subcommittee Chairman Casey, Subcommittee Ranking Member Cassidy, Chair Murray, Ranking Member Burr, and Members of the U.S. Senate Committee on Health, Education, Labor, and Pension's (HELP) Subcommittee on Children and Families, thank you for the opportunity to testify today.

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Xavier's mission since 1925, in part, has been to contribute to the promotion of a more just and humane society by preparing our students to assume roles of leadership and service in a global society. We do this by cultivating a diverse learning and teaching environment that incorporates all relevant educational means—including research and community service. Our students can engage in a world class practical liberal arts curriculum while living out the mission of our university.

I was asked to testify before the Committee today to address the importance of strengthening the continuum of mental health support for all adolescents, particularly in the years leading up to and during the transition from high school to college. I will do that, and of course I will also offer a particular lens which allows me to address the issues confronted by African Americans and those choosing to matriculate at HBCUs.

Chairman Casey, most students who entered Xavier University of Louisiana in August, have never known a world without Facebook or war. While I learned how to exit the building in a single file line in preparation for a potential fire, my students have learned how to "run, hide or fight" their way out of an active shooter situation. They are all too familiar with social, political and racial unrest in this country, and they have probably participated in more marches or rallies than most of us in this room. They have lived through global economic recessions that resulted in some family members losing their jobs, homes and overall financial instability.

They are also still in the midst of a global pandemic that caused the entire world to stand still and reimagine what normal looks like. Some of these young people lost multiple family members due to COVID related illnesses, in part, because they lacked access to affordable healthcare and, also, had family members whose primary source of income meant their status as front line workers was non-negotiable. Whether they are from Staten Island, Chicago or New Orleans, they were well acquainted with loss, long before the pandemic as they routinely attended candlelight vigils, memorials and funerals for friends who died due to gun violence, drug addiction, or suicide.

What our students at Xavier experience mirrors what their peers are experiencing across the country. In a 2022 *Chronicle of Higher Education* article entitled, "Overwhelmed: The real campus mental-health crisis and new models for well-being", researchers suggest:

> The prevalence of anxiety and depression is rising across the country, particularly among young people. College students of all ages are more distressed than ever before, and increasing shares are enrolling with mental-health histories, in terms of diagnoses, treatment, and medication." Institutions like Xavier University are challenged to recreate systems of care and support to meet the growing needs of a very different student body.

According to data cited in a 2022 article in the *Journal of Affective Disorders*, "By nearly every metric, student mental health is worsening." During the 2020—2021 academic year, more than 60 percent of college students met the criteria for at least one mental health problem, according to the Healthy Minds Study, which collects data from 373 campuses nationwide (Lipson, S. K., et al., Journal of Affective Disorders, Vol. 306, 2022). In another national survey, almost three quarters of students reported moderate or severe psychological distress (National College Health Assessment, American College Health Association, 2021). While students and the lived experiences they bring to campus have evolved and changed, the funding to take good care of those students has not although the demands for that funding have increased dramatically.

Penn State's Center for Collegiate Mental Health shared, "That rising demand (for mental health care) hasn't been matched by a corresponding rise in funding, which has led to higher caseloads." nationwide, the average annual caseload for a typical full-time college counselor is about 120 students, with some centers averaging more than 300 students per counselor (CCMH Annual Report, 2021). The number of students seeking help at campus counseling centers increased almost 40 percent between 2009 and 2015 and continued to rise until the pandemic began, this is according to data from Penn State University's Center for Collegiate Mental Health (CCMH), a research-practice network of more than 700 college and university counseling centers (CCMH Annual Report, 2015).

We, like so many of our peers, know that we can't do it alone and are developing strategic relationships with our K–12 partners and our parent community. We've learned that the habits of self-care that our students bring with them are informed, in part, by their environment. Access to healthcare, specifically mental healthcare, is not always readily available to students who come from rural areas, inner cities or economically depressed communities. Most colleges and universities are the direct beneficiaries of the Coronavirus Aid, Recovery, and Economic Security (CARES) Act, Public Law 116–136; the Higher Education Emergency Relief Fund (HERF II) of the Consolidated Appropriations Act of 2021, Public Law 116–260; and the HEERF III authorized by the American Rescue Plan (ARP), Public Law 117–2. These critical legislative lifelines allowed colleges and universities to maintain university life for our students throughout the pandemic. In fact, at Xavier, we were able to expand the reach of our Counseling and Wellness office by adding additional therapists, offering enhanced services and training our community on mental health first aid. The traditional HEERF funding along with the funding allotted specifically to HBCUS, Tribal Colleges and Universities, and Minority Serving Institutions (MSI) were used to increase these services. We are acutely aware that these funding sources have an expiration date, and while we are working alongside community partners to identify other resources that may fill the gaps that will be left as the funding sunsets, one of our asks today is that sunset deadline be extended through at least August 31, 2026.

The HBCU bomb threats of 2022 have altered the higher education landscape for every student studying at an historically Black college to better their life. For this specific set of institutions, only, to be singled out and threatened repeatedly has caused our students—Black students already who have likely overcome significant societal pressures to find themselves on the verge of a life changing degree—untold

mental anguish and stress. Although the prosecution of those who maliciously caused this situation is a law enforcement issue, the impact on our students is not. Specific mental health focus should be directed to us as the sole recipients of these threats. The Commerce, Justice, and Science (CJS) Appropriations bill for fiscal year 2023 should have language that guides the funding for National Joint Terrorism Task Force's ability to harden campuses specifically to HBCUs instead of generally extending the funds to states who do not report back to Congress which institutions receive it and likely award the funding to their "flagship institutions." Additionally, the Senate HELP Committee must pass the IGNITE HBCU and MSI Excellence Act (H.R. 6893) to improve HBCU facilities, harden the campuses to reduce the likelihood of these kinds of threats, and allow the cyber-related infrastructure to be strengthened enough to track these threats when they occur.

While the national landscape as it relates to mental health with young people can appear bleak, I like my fellow Arkansan, President William Jefferson Clinton, *still believe in a place called Hope*. I'm hopeful because of the resilience of our students and the generation from which they come. However, for them to achieve success, we must dismantle outdated systems that were not designed for their success. So, Madam Chair, I want to leave you with some recommendations:

- Similar to guidance offered by the Office of Civil Rights related to Title IX, the Department of Education should consider offering guidance on mental health first aid to support educators and administrators for all K–16 institutions which receive Federal funding.
- The Department of Education should consider extending the funding period for the HEERF I, II, and III as well as the HBCU, TCU, and MSI set aside funding until August 31, 2026, which will allow colleges and universities to continue to provide uninterrupted coordinated care to our students as they transition to campus.
- HELP must push the Senate to "redline" H.R. 6893, the IGNITE HBCU and MSI Act to improve HBCU facilities in response the HBCU bomb threats and increase a sense of security on the campuses. The fiscal year 2023 CJS Appropriations bill must also include guiding language to direct funding to HBCUs to harden their campuses in response to the HBCU bomb threats.
- Financial stress is one the of most prevalent causes of anxiety for students entering college across the country. Congress should continue to advance common-sense legislation to reduce the costs of higher education and support President Biden's plan to address college debt through limited student loan forgiveness.
- As previously mentioned, students arrive on campus with few coping skills as well as co-morbidities that impact their academic success. Earlier intervention would provide those students with the strategies and resources that they could equip them with tools for success. With that being said, Congress should follow the lead of Senators Casey and Cassidy and pass S. 4472 the Health Care Capacity for Pediatric Mental Health Act and S. 2550, the RISE Act.

For more information and details regarding my remarks, I ask that you read my written testimony submitted for your review.

The CHAIRMAN. Dr. Wright, thanks very much for your testimony.

Dr. Weiss.

STATEMENT OF ASHLEY WEISS, DO, MPH, DIRECTOR OF MEDICAL STUDENT EDUCATION IN PSYCHIATRY, TULANE UNIVERSITY SCHOOL OF MEDICINE, NEW ORLEANS, LA

Dr. WEISS. Thank you for having me here, Chairman Casey, and Ranking Member, Dr. Cassidy, and the rest of the Committee.

Again, my name is Ashley Weiss. I am a Child and Adolescent Psychiatrist at Tulane School of Medicine in New Orleans, Louisiana. I specialize in first episode psychosis. Psychosis is a symp-

tom typically associated with the onset of schizophrenia and bipolar disorder.

These illnesses can have devastating consequences, from the increased risk of cardiovascular disease and premature death, to the ramifications of being chronically marginalized by society. Why am I bringing up illnesses like schizophrenia in a hearing about mental health and high school and college students? It is because this is where they start, in our young people and not by any fault of their own.

Adolescence is a time of incredible brain maturation, and for some, this maturing process goes awry, leading to the emergence of severe psychiatric disorders. These illnesses don't discriminate. They were present pre-COVID, and they are still present now with a little bit of a different context.

Globally, these illnesses lead to the greatest costs, both directly and indirectly. So what is psychosis? Psychosis can be described as a loss of touch with reality. Examples of psychosis symptoms are hallucinations, confusion, and delusions.

These experiences start small, like mishearing sounds as voices or beginning to feel as if people are watching you. This paranoid feeling could turn into a belief, a delusion, where one is convinced the world is literally out to get them. And it is difficult but very necessary to imagine what this might feel like for a young person.

Some facts about psychosis. 3 out of 100 people will experience psychosis in their lifetimes, mostly occurring for the first time between ages 16 and 25. For every one person experiencing psychosis, six other friends or family are directly impacted.

In the U.S., the average time one experiences psychosis prior to treatment is 72 weeks, not days, weeks. 1 in 10 will attempt or complete suicide with the highest risk being after the first episode.

To give these statistics a local context, George Washington University enrollment is about 26,000 students, which means almost 800 will experience psychosis annually and will not receive appropriate care for over a year.

Over 4,500 friends and family are impacted. Nearly 80 will attempt or complete suicide. So there is a sense of urgency because time is not on our side. The impact of the brain can be deteriorating.

The last three decades of research show that specialized intervention as early as possible after psychosis onset improves outcomes across the board. There is no time to wait. The same philosophy is already accepted in stroke intervention and should be accepted in psychosis intervention as well.

In 2015, I started the Early Psychosis Intervention Clinic in New Orleans. We have treated nearly 100—nearly 1,000 people since we opened our doors. Our multidisciplinary team provides coordinated specialty care, including medication management from psychiatrists, individual family, and group therapy, and wellness coaching.

All treatment is deeply individualized, with the goal of getting young people back on track, and that often means back to school or graduating or to their first job. But what we do in the clinic is

not enough. Because of the need for early treatment in psychosis, we are forced to think about early detection.

We have a robust early detection campaign called Calm, which was mentioned, and this aims to educate the community about psychosis, debunk myths, reduce stigma so hopefully people will feel comfortable and safe coming forward for treatment.

Our goal is that an individual comes forth on their own and they don't have to wait for someone else to bring them in, and they certainly don't have to wait for the police to pick them up having an acute psychosis and take them to the emergency room.

There are significant challenges and barriers that must be considered. For most people, recovery can take many, many months, but time continues to pass for everyone else in their lives. Their friends have often moved on, graduated, moved away to college, or started their first job. They often feel misunderstood, ashamed, quickly leading to the loss of confidence and increased isolation.

There is a conspicuous gap in school based recognition of these needs for these individuals and keeping them engaged or even welcoming them back after their recovery. I have multiple college students in my program.

Students in every college in Louisiana, actually, which makes me very proud, who didn't even know that they were eligible for retroactive medical leave that would erase incompletes from their transcripts, who have crushing student loan debt from the semesters that they became ill. We are often the first place to provide guidance in how to approach these issues. There are financial threats to programs like ours.

Although our program is committed to long term care, most programs like ours don't go beyond two to 3 years. We are now realizing that people lose their gains when they lose specialized care. But how do we pay for continued care?

We have subsidized our growth through the Congressional legislation mandating a portion of the SAMHSA block grant be set aside for early, severe mental illness. We appreciate this opportunity because it covers the necessary care that is not covered by insurances.

In our State of Louisiana, Medicaid and commercial insurers do not reimburse any of the coordination of care that is required to provide this model. No case management, no record review, no coordination with community partners like schools or hospitals, no treatment team meetings.

Without the coordination, the risk of relapse increases exponentially. And commercially insured patients might have two co-pays a week, that will quickly add up after a month, and that becomes unattainable.

People in this age group fall off their parents' insurances and they might not even qualify for Medicaid. And then barriers exist beyond our clinic. There is a pervasive lack of education coupled with ample misinformation about psychosis and what it even is.

This gap in education exists in the general public but extends even to mental health professionals. Psychosis is not a topic in

health education curriculums for high school or college students, even though their age group is most at risk.

Psychosis education is not a prominent part of the curriculum for those interfacing with high risk groups. Psychosis intervention is far from being considered an essential part——

The CHAIRMAN. Doctor, we have to wrap up.

Dr. WEISS. Okay. Can I have a 10 second wrap up?

The CHAIRMAN. Sure.

Dr. WEISS. Okay. I am here today to say out loud for the record that our youth and young adults are the vulnerable ones to these illnesses, and we cannot ignore this fact as a society any longer.

These illnesses are not curable, but they should not be associated with an inevitable lack of productivity and institutionalization. They are not preventable, but there are strategies to mitigate risks, such as early detection. They are manageable, and management does not mean doing the bare minimum.

That approach has not served us well historically, and we need to do better for our people. It is a necessity for them. We must be ambitious in our commitment to these youth and young adults so that their recovery is supported while they explore their opportunities that they deserve and expand their futures.

[The prepared statement of Dr. Weiss follows:]

PREPARED STATEMENT OF ASHLEY WEISS

My name is Ashley Weiss. I am a child and adolescent psychiatrist at Tulane School of Medicine in New Orleans, Louisiana. I specialize in first-episode psychosis. Psychosis is a symptom typically associated with onset of schizophrenia or bipolar disorder. These illnesses can have devastating consequences, from the increased risk of cardiovascular disease and premature death, to the ramifications of being marginalized by society. Why am I bringing up illnesses like schizophrenia in a hearing about mental health in high school and college students? Because this is where they start, in our young people, and not by any fault of their own. Adolescence is time of incredible brain maturation, and for some, this maturing process goes awry, leading to the emergence of severe psychiatric disorders.

What is psychosis? Psychosis can be described as the loss of touch with reality. Examples of psychosis symptoms are hallucinations, confusion, and delusions. These experiences start small, like mis-hearing sounds as voices, or beginning to feel as if people are watching you. This paranoid feeling could then turn into a belief, a delusion, where one is *convinced* the world is literally out to hurt them. It is difficult, but necessary, to imagine what this may feel like.

Some facts about psychosis:

- 3 out of 100 people will experience psychosis in their lifetimes
  - Mostly occurring for the *first time* between 16 and 25 years old.
- For every 1 person experiencing psychosis, 6 more friends and family are directly impacted.
- In the US, the average time one experiences psychosis prior to treatment is 72 weeks
- 1 in 10 will attempt or complete suicide with the highest risk after the first episode

To give these statistics a local context:

- George Washington University enrollment is about 26,000 students
- Which means, almost 800 will experience psychosis annually and will not receive appropriate care for over a year
- Over 4500 friends and family are impacted
- Nearly 80 will attempt or complete suicide.

There is a sense of urgency because time is not on our side when it comes to psychosis and its impact on the brain. But the last 3 decades of research shows that *specialized* intervention as early as possible after psychosis onset improves outcomes across the board. There is no time to wait. The same philosophy is already accepted in stroke intervention and should be in psychosis intervention as well.

In 2015, I started the Early Psychosis Intervention Clinic in New Orleans. We have treated nearly 1000 people since we opened our doors. Our multi-disciplinary team provides coordinated specialty care, including medication management from psychiatrists, individual and family therapy, groups, and wellness coaching. All treatment is deeply individualized, with the goal of getting young people back on track, and often this means back in school.

But what we do in the clinic is not enough. Because of need for early *treatment* of psychosis, we are forced to think about early *detection*. We have a robust early detection campaign called CALM-Clear Answers to Louisiana Mental Health that aims to educate the community about psychosis, debunk myths and reduce stigma, so hopefully people will seek help for themselves or their loved ones sooner than later.

There are significant challenges and barriers that must be considered. For most people, recovery can take many months, but time continues to pass for everyone else in their lives. Their friends have often moved on, graduated, moved away to college, or started their first job. They often feel very misunderstood and ashamed, quickly leading to loss of confidence and increased isolation. And there is a conspicuous gap in school-based recognition of the needs of these individuals, in keeping them engaged, or welcoming them back during recovery. I have multiple college students in my program who didn't know they were eligible for retroactive medical leave that may erase incompletes from transcripts, who have crushing student loan debt from the semesters they became ill. We are often the first place to provide guidance in approaching these issues.

There are financial threats to programs like ours. Although our program has committed to long-term care, most programs like ours do not go beyond 2 or 3 years, and we are realizing now that people lose their gains when they lose specialized care. But how do we pay for continued care? We have subsidized our growth through the congressional legislation mandating a portion of a SAMSHA block grant be 'set-aside' for early severe mental illness. We are appreciative of this opportunity because it covers the necessary care that is NOT covered by insurances. In our state, Medicaid and commercial insurers do not reimburse ANY of the *coordination of care* services-no case management, no record review, no coordination with community partners like hospitals and schools, no treatment team meetings-and without the coordination, the risk of relapse increases exponentially. If commercially insured, patients may have 2 co-pays a week for treatment which quickly adds up and becomes a burden. People in this age group also fall off their parents' insurance but may not qualify for Medicaid.

Barriers exist beyond the clinic. There is a pervasive lack of education (coupled with ample misinformation) about what psychosis even is. This gap in education exists in the general public but extends even to mental health professionals. Psychosis is not a topic in health education curriculums for high school or college students, even though their age-group is the *most* at-risk. Psychosis education is not a prominent part of the curriculum for those *interfacing* with the high-risk groups, for instance teachers and school-based mental health professionals. Psychosis *intervention* is far from being considered an essential part of school-based healthcare. At this point, we should not be surprised when a college freshman experiences psychosis, we should be *anticipating* this, working to disseminate knowledge about early warning signs, and strategically planning with community partners to ensure students get back on track once well.

I'm here today, to say out loud and for the record, that our youth and young adults that are the topic of this hearing are the vulnerable ones, where the *severe* mental illnesses strike. We cannot ignore this fact as a society any longer. These illnesses are *not curable* but they should not be associated with inevitable lack of productivity and institutionalization. They are *not preventable* but there are strategies to mitigate risks associated with earlier onset such as substance use. They *are manageable* but management doesn't mean doing the bare minimum. That approach has not served us well historically. A specialized approach may require a weekly meeting with their team for years, however, if that means individuals have more opportunities, more graduations, more jobs, more meaningful relationships, improved quality of life, then we are in a better place. If our communities have fewer suicides, fewer inpatient psychiatric hospitalizations, fewer ER visits, fewer people

living in poverty, then we are in a better place. We collectively benefit from a progressive and more accurate narrative about psychosis, but for our young people, it is necessity. We must be *ambitious* in our commitment to these youth and young adults, so that their recovery is supported while they explore opportunities and expand their futures.

The CHAIRMAN. Doctor, thanks very much.

We will conclude now with Brooklyn Williams.

STATEMENT OF BROOKLYN WILLIAMS, HIGH SCHOOL SENIOR AND FOUNDER OF THE CHILL CLUB, PITTSBURGH, PA

Ms. WILLIAMS. Senator Casey, Senator Cassidy, thank you for listening to my story. And everyone else here, thank you for listening to my testimony. Looking at me, you might not suspect that I am dealing with a lot of internal struggles.

I am speaking in public so you might not suspect that I have severe social anxiety. I cover my eye bags, and no one tells that I struggle with insomnia. I ate my entire breakfast this morning, but I still have bulimia.

I got out of bed and did my hair, so to not look depressed. Just because I did not fit the description of someone with mental health problems that does not mean that I am fine, and I feel like we as a society overlook people with these health issues because they do not fit into the concrete mold in the textbooks of mental health symptoms.

There is a fluidity in the way each of us experience mental health, and I feel like schools and communities only intervene when it becomes intensely severe, or in unfortunate cases too late. In my experience, mental health highs and lows happen in waves, always sporadic, and most recently due to being a high school senior, in my last year of childhood.

As a child, I do not remember feeling there was any disordered thinking in my life. Yet looking back on it, I feel that mental health was not ever a topic of conversation at school or home until I was 18.

When I was 13, my mom passed away from stage four metastatic breast cancer after a 10 yearlong battle with the disease. Losing her devastated my family and I, and I felt like a portion of myself died with her. As much as I love my dad and my siblings, my mom was my lifeline and my best friend.

Although we tried to prepare as much as possible for her passing, it was the worst feeling that I have ever experienced. The following year was a blur of numbness and therapy sessions, but the pandemic caused everything to shut down and I felt alone.

To combat those feelings of grief, depression, and isolation, I started to paint and do crafts to cope. It helped me express and lose myself in an activity rather than sulk in my emotions. Once school started up again, I thought, if this is making me feel better, then maybe it will make others feel better too.

I started the Chill Club where we do activities like meditation, yoga, crafts and painting every month as a group to come together and talk about our shared emotions and not worry about the problems in our lives.

From starting my club 2 years ago, I have been graced with many opportunities that helped me to share my story and cope with the loss of my mom and the struggles resulting from that, but I feel there is a long way to go. Incorporating mental health topics from an early age would be the first steppingstone I would take to support people's needs.

Talking about these issues with teens before they are reaching for help. Providing more accessible outreach professionals in schools, having all students speak to these professionals and not only the ones that come for help.

Allowing for mental health absent days to be excused, just like having physical illnesses, because mental health and physical health are equally as important. Allowing for anonymous assistance would also be effective because it is evident that most teens do not want to ask for help publicly.

Last, professionals working with teenagers should be more open and equipped to talk about mental health struggles by being provided with the correct necessities to help teens work through their problems. As a high school senior, I have grown to see that the process of moving from adolescence to adulthood is tricky enough with college essays, picking a major, and knowing that I will leave my childhood behind.

Providing teens with assessable professionals to speak with will only benefit our communities. Everyone needs to be aware of their mental health because it is not selective or to be stigmatized or to be put aside because it is too hard to understand.

Working through these issues will not only give opportunities for teens to grow and flourish into adults, but also to allow our communities to be stronger as we improve the way of life one kid at a time. Thank you.

[The prepared statement of Ms. Williams follows:]

PREPARED STATEMENT OF BROOKLYN WILLIAMS

Thank you to all who listen to my story. Looking at me you might not suspect I am dealing with a ton of internal struggles. I am speaking in public so you would not suspect that I have severe social anxiety. I cover my eye bags so no one can tell I struggle with insomnia. I ate my entire breakfast this morning but I still have bulimia. And I got out of bed and did my hair, but I do not "look depressed". Just because I do not fit the description of someone with mental health problems does not mean that I am fine and I feel we as a society overlook people with these health issues because not all of us fit into the concrete mold in the textbooks of mental health symptoms. There is a fluidity in the way each of us experience mental health, and I feel schools and communities only intervene when it becomes intensely severe or in unfortunate cases, too late.

In my experience, my mental health highs and lows happen in waves. Always sporadic and most recently due to me being a high school senior in my last year of childhood. As a child I do not remember feeling like there was any disordered thinking in my life, yet looking back on it, I feel that mental health was never a topic of conversation at school or home until I was a teen. When I was 13, my mother passed away from stage 4 metastatic breast cancer after a 10-year long battle with the disease. Losing her devastated my family and I felt like a portion of myself died with her. As much as I love my dad and my siblings, my mother was my lifeline and best friend and although we tried to prepare as much as possible for her passing it was still the worst feeling I have ever experienced. The following year was a blur of numbness and therapy sessions, but the pandemic caused everything to shut down and I felt alone.

To combat those feelings of grief, depression, and isolation, I started to paint and do crafts to cope. It helped me to express myself and lose myself in an activity rath-

er than sulk in my emotions. Once school started again I thought "if this is making me feel better maybe others will feel better too". So I started the Chill Club where we do activities like meditation, yoga, crafts, and painting every month as a group to come together to talk about our shared emotions and not worry about the other problems in our lives.

From starting my club 2 years ago to now I have been graced with many opportunities that have helped me to share my story and cope with the loss of my mom and the struggles resulting from that, but I feel there is still a long way to go.

Incorporating mental health topics from an early age would be the first stepping stone I would take to support people's needs. Talking about these issues with teens before they are calling out for help. Providing more accessible outreach professionals in schools and having all students speak to these people, not just the ones that come for help. Allowing for mental health absent days to be excused just like having a physical illness because mental health and physical health are equally as important. Allowing for anonymous assistance would also be effective because it is evident that most teens do not want to ask for help publicly. Last, professionals working with teenagers should be more open and equipped to talk about mental health struggles by being provided the correct necessities to help teens work through their problems.

I have grown to see that the process of moving from adolescence to adulthood is tricky enough with college essays, picking a major, knowing I will have to leave my childhood behind. So providing teens with accessible professionals to speak with will only benefit our communities. Everyone needs to be aware of their mental health because it is not selective or to be stigmatized or put to the side because it is "too hard" to understand. Working through these issues will not only give opportunities for teens to grow and flourish into adults, but to also allow our communities to become stronger as we improve the way of life one child at a time.

The CHAIRMAN. Well, Ms. Williams, thanks very much for your testimony. And I want to thank the testimony of all our witnesses, and especially to you for demonstrating uncommon courage at any age, but we have rarely heard testimony like the testimony you presented today, so we are thankful that you are here with us.

I will start a round of questions. I will just do one question to expedite our schedule a little bit. I will start with Dr. Wright. In your testimony, you described how a large number of students at your university are struggling with mental health.

Given that around half of mental health conditions begin by age 14, it is likely that many of the challenges that you are seeing, of course, started long before college. In addition to school staff, parents can be a child's strongest advocate to help with getting the needed support that they require. But these families, these parents need to know what to watch out for in their children.

How should we begin engaging families so that they are aware of the signs that their child may have a mental health, developmental, or learning disability?

Dr. WRIGHT. Thank you, Senator. That is an amazingly profound question. And when you think about the intersections of our students and their families, where they are coming from.

Many of our students come with these undiagnosed challenges. So when they first have their first moment, we don't know what to do, and neither do they.

I really believe that the work that you all are advancing in your bill, the Pediatric Access Act, will help with that because providing more touch points, training folks from the very beginning, having mental health first aid in our high schools and our elementary schools, but also in our community centers and in our churches.

Faith communities. I think so many of our families have been told that mental health is a secret, and they won't allow their students or kids to get help. So we have got to create some level of understanding that mental health is tantamount to having diabetes.

If someone has a heart attack, we don't keep them hidden away but we rush them to the hospital. And when someone is having these symptoms, we need to do it. So removing the stigma of mental health is one of the first things, but then educating their parents on how to connect them with folks in the community.

In rural spaces that might be harder. So working with them in their schools, with their counselors, working with them in their—in some spaces in their housing authority places or their therapist or their counselors there, but I do think being able to expand the reach of qualified mental health professionals in these spaces will allow those parents to see those warning signs, because many of our students' parents may not have been trained to know what to look for.

But providing schools, community organizations, resources to help them, I think will be essential in that.

The CHAIRMAN. Great. Doctor, thank you very much. I will turn to Ranking Member Cassidy. I will reclaim some of my time later.

Senator CASSIDY. I will defer to Senator Tuberville and allow a colleague to go.

Senator TUBERVILLE. Thank you very much. Thank you for being here today. This is important. I don't think people really know how important it is. I coached for 40 years. I coached in eight states.

I went to high schools all over this country, and in the 80's and 90's we had a mental health problem. But after 2000, after the internet and this thing right here came out, it has devastated our kids, and I saw it every day. So this is a huge problem. It is going to get worse before it gets better.

Dr. Wright, I am like you, faith based family—I mean, that is how we are going to overcome a lot of this. It is going to have to come through that, but we have got to be prepared. We have got to be able to recognize a problem.

Dr. Hoover, for years I saw kids come play for me and a lot of them came in, and early in my career, with very little problems. Last 20 years, they came in and they had ADHD. They said they did, and we were giving them drugs right and the left. We weren't—the doctor were prescribing them.

Do we have a medication problem in this country when it comes to mental health?

Dr. HOOVER. It is a good question. And first of all, Senator Tuberville, I want to thank you for your coaching years, because we know that all of the adults, as was said earlier, by Chairman Casey, all of the adults have a responsibility to take care of the mental health of our young people, including our coaches.

I was on a plane yesterday next to a school bus driver, and I was telling her that she has one of the most important jobs when it comes to actually supporting the everyday experience of our young people and their mental health.

In terms of medication and the diagnoses that seem to be increasing, part of it, I would argue, is really that we are just becoming more aware of the mental health needs of our young people. I would say that our medications are far from perfect.

In fact, many would argue that they are imperfect solutions to the mental health challenges of our young people.

But there is also strong evidence that some of the medications for our children and adolescents, including for ADHD, as you mentioned, and other mental health challenges, have been effective, but they are most effective when combined with other interventions, and that includes mental health interventions provided by licensed counselors, social workers and psychologists, but also the everyday supports, whether it is from the faith community, from families, or from schools.

It is not a one size fits all approach and it is not a one intervention approach. In fact, most of the data would agree that medication, combined with other interventions, is probably the most effective for some of our most debilitating disorders.

Senator TUBERVILLE. Thank you. Dr. Weiss, we locked these kids down for several years. Fortunately, in Alabama, we didn't do as much. And we had a study come out not too long ago.

We went from 49 to 39 in some areas of our scores improving. We went from 40th in the country to first in the country in graduation rate because we stayed in school. My question is, we have already spent so much money on a lot of these problems.

In your opinion, how do we best direct these funds in the future to help with mental health?

Dr. WEISS. I have to—full disclosure, I am from Alabama and grew up with Auburn football, so——

[Laughter.]

Senator TUBERVILLE. Well you did good. I should have asked you in the first place——

[Laughter.]

Dr. WEISS. The work that I do is addressing severe mental illnesses that have long been underfunded. This—we don't have a good track record historically of taking care of those with the most severe mental illnesses and they really weren't given opportunities to complete school, to go to higher education.

Now we have them actually getting well after their first episode with a severe illness, just like you could get well with diabetes diagnosis early, just like you could get well with other major medical problems.

The cost needs to be reflective and encompass what it takes to scaffold them into these opportunities that they really haven't had before. And that might be more costly than to support a kid with ADHD from high school to college.

However, we are just really learning now in the last 10 years what that is going to look like for this country. So because early intervention and severe mental illnesses is such a new concept, and literally we are talking about the last 10 years of clinics, the last 20 years of research.

Senator TUBERVILLE. Dr. Hoover, I know we are talking about going to high school to college. Half the kids in this country don't go to college. They get a job. They get in the military. How do we help them? How do we evaluate them? Because most kids that go to college get some kind of valuation through the process of higher education. How do we help those kids don't go to college?

Dr. HOOVER. It is a great question. And when I saw the subject of today's hearing, I was hoping that it was—it would go beyond just college, because we know so many young people don't go on to college.

I would wish that we had better supports in place for them. I mean, I do think it really speaks to the first issue that was brought up that we need to start earlier. The supports that we are talking about from high school to college are critical.

But what is more critical is that we put systems in place from pre-K to K–12 to actually identify and provide scaffolding and structured support for their mental health. And that doesn't just mean—I think our young panelist, as usual, said it best, which was we can't wait until there is a crisis.

We can't wait until things get really bad to provide services. We need to be doing mental health literacy in the classroom. We need to be putting systems of identification into their hands, whether it is in schools, on college campuses, or in their communities. I think the efforts to support integration into primary care are critical.

For those who do go on to career, maybe not college, they can get some of those same supports in their primary care setting. Or in other natural settings, whether that is their faith community, whether that is their family.

There are many interventions that can support families to better equip them to support their young people, including as they transition to adulthood. So we need to not just put these services in schools or primary care, but we need to put them in the hands of families.

Senator TUBERVILLE. Dr. Wright, you got to comment on any of that, about kids that don't go to college? You see probably a lot of those.

Dr. WRIGHT. We do in just—in communities in general. And I think as she was describing, being able to put those—have them access those resources in other spaces. There is dignity and honor in our work but sometimes we privilege, this transition. The way that—my profession.

But being able to make sure that they have access to an affordable health care so that they can afford to take advantage of that, whether it is through state sponsored Medicaid or private insurance. But I do think that being able to recognize that we all live within the context of our lives and learn within the context of our lives, that there is support in their spaces of work and worship.

Then they have the ability to talk with their family because, again, secrets are the things that kill us. And so but, yes, I absolutely agree with what she said.

Senator TUBERVILLE. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Tuberville.

We turn next to Senator Smith.

Senator SMITH. Well, thank you, Senator Casey and to Senator Cassidy, who I believe had to leave, for pulling together. I really appreciate. It is a great panel.

I think the people here in this room today believe that mental health care is health care and that every young person deserves access to the mental health care that they need. And yet, I think we also know that we failed in that mission, but we are working hard on it.

Everybody in this room, I think, in one way or another on this side has been working to expand access to mental health care in schools. I certainly have with legislation that I have introduced.

Let me ask you, Ms. Williams, if I could, so I first realized that I was suffering from depression when I was in college. I am quite sure now that I was having that experience when I was in high school, but I didn't quite understand what was going on. I didn't really see how it was incapacitating me.

I am quite sure now that my experience wasn't unique. It seems like with physical health care we do a lot of thinking around preventative care and early intervention, but yet what happens with mental health care is you get to a crisis point where you are really incapacitated and then you are sort of starting from behind.

I am wondering if you could just say from your perspective, like what that might look like in a high school setting where you are getting at it, getting at people's challenges earlier rather than later?

Ms. WILLIAMS. Yes, so I feel like in my experience, I really—I was behind like how you said. I started becoming really low in my depressive state before I thought to seek help. But I feel like now, nowadays there is a lot more—it is a lot more noticeable because of social media or being online and talking.

Like people just say anything nowadays and they talk about all the things in their lives. So like really just getting out there and saying that they are not feeling like the way they should or something. It really brings out the topic more. But I feel like starting at a young age, I feel like that would be a lot more beneficial for kids to learn about what is going on and start seeing the signs.

If they don't feel like they want to go outside or go to school or not feel the way they should feel, or they feel like they might be a little bit different, they should always have someone to talk to. And I feel like the first step to do that is to get everyone, get everyone like the care they need beforehand so nothing will escalate and get too great that no one can control it.

Unfortunately, there is so many cases of suicides and people going to psychiatric wards and stuff like that because they haven't got the help that they needed. And I have definitely seen that in my personal life. There is a lot of kids in my surrounding schools and even in my school that have lost their battle to depression or anxiety and stuff.

I feel like that should be a lot more preventable if we take the steps to reach out to their therapists and get them into schools

more. Because I definitely see that also we have a school therapist on my school, but there is not that many people that are aware that there is a school therapist or have access or know the way to get to the therapy that they need or talk to the counselors, because there are thousands of kids inside one school at one time and there are four or five counselors for those thousands of kids.

Senator SMITH. Right, right. The part of it is not having enough—not having enough providers of therapy in schools. And part of it is making sure that people see the pathway from the way that they are feeling to the help that is there that they might not even realize is there, right?

Ms. WILLIAMS. Yes.

Senator SMITH. Let me just ask really any of the other panelists, I am very interested in how we can integrate physical health care and mental health care in a doctor's office setting too. And at the pediatric level, what kind of integration can we do there?

I am just wondering if you have any insight for us as we think about that, because it seems to me that a lot of folks, assuming they have access to health care, and God knows not everybody in this Country does have access to health care, physical health care. Kind of what we have seen.

Maybe, Dr. Hoover, you would like to address that.

Dr. HOOVER. I would be happy to. Thank you for the question, and I appreciate your asking, again, our youngest member of the panel first, because I think when we speak to our youth about kind of their ideas of how we can get services and supports to them, they usually have the best answers.

With respect to better integration into primary care, first of all, it can happen out in our pediatric, mental health clinics, and our young adult clinics. We often have this bifurcation. It is a really artificial bifurcation between pediatric medical care and adult medical care.

I would argue that we shouldn't just drop young people off at the age of 18 and say that they have to switch to an adult provider, that is No. 1. But in terms of integration into primary care, it can happen both in those health care settings, but also in health care settings in schools.

School based health centers, I appreciate the investment in school based health care. More young people are able to access primary care when it is offered in the context of school based health.

Whether it is out in the community, in primary care, or in the context of a school based health center, we have wonderful examples of mental health, behavioral health providers situated in those settings, but we also have many examples, especially in a more rural or smaller campuses, where they don't have the provider network to be situated physically in the building.

We actually have wonderful examples of effectively using telemental health to integrate right there into the mental health—or excuse me, into the primary care setting. And the last thing I will note is just the increased investment in the child psychiatry access programs are now called the primary care, the mental health and primary care access, where you have primary care providers that

can pick up a phone or get on tele and actually reach out to a specialty mental health provider, have been instrumental.

I really appreciate the expanded coverage of that. We have seen it not only in primary care can be critical, but also in the context of schools.

Senator SMITH. Thank you. Chairman Casey, I know I am out of time. I am going to submit for the record a question that I have also around the sort of—the plethora proliferation of mental health care apps. And I am trying to understand the efficacy of those and what kinds of consumer protections we need to think about for those. Thank you very much.

The CHAIRMAN. Thank you, Senator Smith.

I will turn next to Ranking Member Cassidy.

Senator CASSIDY. I will defer to Dr. Marshall.

Senator MARSHALL. Thank you, Senator Casey. Thank you, Senator Cassidy. Again, thanks to all of our panel for being here. And especially Ms. Williams, thank you for coming. You are absolutely the most courageous person I will meet today, to come and share your story. You may be the most courageous person I will meet all week and all month, and I got a question for you in a second.

My first question is going to be for Dr. Weiss and Dr. Hoover. Prior authorization, access to care has been a bigger issue—is the No. 1 physician administrative concern in America. As an obstetrician, I saw the issue delay care for infertility patients, for high risk patients.

My friends in orthopedic surgery tell me that it is getting harder and harder to get the joint replaced and maybe that the process delays it three or 4 months' time. And meanwhile, we get the patient addicted to two narcotics.

I am just curious, in your clinical experience, when it comes to mental health issues, are you seeing any challenges in the prior authorization realm? Dr. Weiss, why don't you go first.

Dr. WEISS. It is mind numbing.

Senator MARSHALL. Mind numbing.

Dr. WEISS. Yes our clinic bills for services and we also have some money that subsidizes what is not covered.

But even the services that are covered, and I deal with a lot of antipsychotic medication and long acting antipsychotic injectables that are not preferred on formulary, but that are the best medications of certain classes of medications that are more appropriate for young patients versus the older ones for many, many more reasons, like less side effects.

It will take weeks sometimes. Getting prior authorization for community based mental health services can sometimes take weeks, and then every 3 months they want you to repeat the authorization.

In Louisiana, Medicaid has been privatized, so there are five companies that provide Medicaid services, each requiring a different type of pre-authorization or prior authorization for services. So this is a job of two or three people.

We have a census of about 170, so it is hard to finance that because I am, aware that businesses need to be financed in a fiscally responsible manner. But the amount of administrative support you need to get these things done is astronomical.

Senator MARSHALL. Yes. Dr. Hoover, do you have anything to add?

Dr. HOOVER. The only thing I would add is I certainly agree with everything you said. And yet, of course, we need some authorization in place, especially for our most vulnerable youth, who may, for example, experience polypharmacy.

Young people in the foster care system, for example, we know may be on multiple medications. There needs to be some authorization and process for understanding the medications that they have been prescribed so that it is done responsibly.

But the wait times for getting into mental health care, as you said, it is mind numbing, astronomical, and for families can be really impossible to navigate.

Senator MARSHALL. In my experiences, what was most frustrating is after my nurses had spent days and days in the back and forth with faxes, not emails or on online, but faxes, eventually I get to talk to a person and maybe it was a neurologist trying to explain to me why we shouldn't be using progesterone for pre-term—have you ever had that same frustration? I wouldn't begin to want to tell you the drugs you should be using.

Dr. HOOVER. Yes. I left inpatient work specifically because of this. I would be told that someone did not qualify for inpatient psychiatric hospitalization because they weren't actively trying to kill themselves or someone else.

I would say, so what about like hearing the demon and coming to get you, and you can't even get out of your bed or go to your house or eat food—you don't qualify for inpatient services. And I just——

Senator MARSHALL. I just want to reassure you that we do have legislation that we could get across the finish line that would impact Medicare, this prior authorization issue. And then we will go after CHIP and Medicaid and some of those others.

I am running out of time. I want to go to Dr. Wright and Ms. Williams for a second as well. One of the tragedies in this country is fentanyl poisoning. And this is an editorial written by a mom from Kansas who lost her son, Cooper Davis, a little bit over a year ago.

A 16 year old who ordered a half of a Percocet tablet via Snapchat, unknowingly laced with fentanyl and the child died. Dr. Wright are you seeing any problems with—the high risk group we are talking about, I am afraid oftentimes they are trying to find Xanax or Adderall or uppers, downers, and they are being laced with fentanyl.

Are you seeing any of this in your world, Dr. Wright?

Dr. WRIGHT. Specifically at my institution, no. We don't see—that is not the drug of choice for our student population. However, prior to Xavier, I lived in Staten Island, and I worked in a private

liberal arts college on Staten Island where we saw a huge problem with the drugs that were laced with fentanyl.

Students who were—whose prescriptions had lapsed, and so now they are going out and finding other ways. And so, yes, that is a huge problem that our young people are dealing with.

It is partly because as Senator Tuberville said, they came medicated, and now they don't have access to those medicines now, and they are trying to find it any way they can. But it is a growing problem, particularly for students who are trying to take care of themselves.

Senator MARSHALL. Sure. Thank you. Ms. Williams, and I certainly don't want to get too personal. I always tell my patients, you can pass on any of my questions, but are do you see any problems, any—are students able to find those types of things online? Do you see it in your school or any concerns about it?

Ms. WILLIAMS. You mean drugs?

Senator MARSHALL. The specifically fake pills laced with fentanyl. Like people are trying to find Xanax or Adderall and my goodness, it has been laced with fentanyl.

Ms. WILLIAMS. Never in my experience have I heard of anyone doing that, no.

Senator MARSHALL. All right. All right. Well, thank you so much. Dr. Weiss, you want—do you have anything to add?

Dr. WEISS. I just—I think one thing that you bring up is important, that every community is different in terms of what very emergent substance use problem is going on. In New Orleans, we have a major problem with synthetics and people smoking mojo and becoming psychotic——

Senator MARSHALL. I don't know what that is.

Dr. WEISS. The point that you can't get them—well, it is just a fake marijuana. I can buy it in a grocery store. I mean, just and it can ruin your kidneys. So you have to be attentive to what is happening in different areas for sure.

The CHAIRMAN. Senator Marshall, thank you.

We will next turn to Senator Kaine.

Senator KAINE. Well, thanks to Senator Casey and Cassidy for pulling this together. And what a great panel. I want to talk a little bit about before college and then want to talk about the transition of college.

I spent Thanksgiving with family and friends, and one of the friends I spent time with is an administrator in the St. John County Florida school system, which includes Saint Augustine, and her responsibility includes all the guidance counselors.

She was telling me, we don't have enough, and they are doing college guidance and helping people with financial aid forms and trying to be counselors. And there are some Florida laws now that are making it even harder because they can't talk about everything with the student without letting parents know.

But setting that aside, the point she was making is there is just not enough people here. So, Ms. Williams, let me just ask you. You

go to Baldwin High School in Pittsburgh. How big is Baldwin High School? How many kids?

Ms. WILLIAMS. It is like 1,400, but it is also with the middle school and high school.

Senator KAINE. It is all—that is all together.

Ms. WILLIAMS. Yes.

Senator KAINE. When you decided, hey, I need to seek help from somebody because of the many issues I am dealing with. And as you described, death of your mom and COVID and there are so many, was it—where did you go? And was it easy to get help or was it hard to get help?

Ms. WILLIAMS. I think I did it the wrong way. But I went to my principal first because I was having trouble with like just trying to get to school and get to do things I wanted to do with my friends and everything. So I went to the principal first because I was closer to him because I didn't have the same guidance counselor of years in my high school.

Senator KAINE. You were getting assigned a different one?

Ms. WILLIAMS. Yes. There was—I think I have had five in the past 4 years, so it was just a little——

Senator KAINE. Is that because you get assigned a different one each year, but also just there is some turnover and people coming in and out.

Ms. WILLIAMS. Yes. It is because—we were supposed to have the same one all 4 years, but because of, COVID and everything, and some people taking maternity leave and different things like that, it was just not consistent, so we just didn't have the same——

Senator KAINE. Well, let me ask Dr. Hoover a question. I am going to come back to you in a minute about college, Ms. Williams. Dr. Hoover, do you think families utilize the IEP process sufficiently to help children deal with emotional and mental health issues?

I have been a Mayor and worked with my school system and am really familiar with IEPs. One of my three kids had an IEP. But commonly for something like a speech therapy or a very narrowly defined learning disability, families can use the IEP process for getting accommodations for students to deal with emotional mental health issues.

Do you think we use that enough in the K–12 space?

Dr. HOOVER. Thank you, Senator Kaine, for the question and for your support of mental health in schools. So the simple answer is, yes, families can use IEP process, and no, they don't use it probably as often or as well as they should have, in part because they are not often aware of how to do it. They don't have the family peer support to help them navigate the process. Of course the stigma——

Senator KAINE. To the extent that there is still any stigma about mental health issues too, that would probably be an additional variable——

Dr. HOOVER. Hugely detrimental. But the other point I want to make, so we need to increase awareness, decrease stigma about

using special education accommodations to support mental, emotional, behavioral issues.

But we also need to provide supports that go outside of or beyond the special education system. There are a lot of young people who could get mental health supports in schools that would not require an IEP, but they can still get mental health support in schools.

Senator KAINE. I want to go over to the college side. So Ms. Williams, you are a senior. So when—are you thinking about going to college next year?

Ms. WILLIAMS. Yes.

Senator KAINE. When you go to college, with the experience you have had and you have now found some support systems that have helped you, and you have created support systems that have helped others, but you are going to show up on a campus where like you will be one of maybe hundreds or thousands and you will be kind of a free agent day one.

What are you going to do when you go to college to try to make sure you have the services that you need? And I ask you this because there might be a lot of people just like you listening to this hearing that would want to hear the way you are going to do it, since you have been appropriately sort of assertive in trying to find the help that you need.

Ms. WILLIAMS. I am thinking about joining different clubs and different social settings that will help me with mental health and other people that deal with the same things that I deal with, and different groups that deal with kids with a parent that passes or a person that deals with depression or anxiety or something like that.

I wanted to join different groups. But I also talked with my therapist a little bit about how to transition from her being my child therapist to becoming—having an adult therapist.

What they were planning on doing is like overlapping sort of the time between her leaving my life and having a new therapist so we can—so she can talk me through the way I should interact with the new therapist and try to overlap them and try to, I don't know, get a way through the——

Senator KAINE. I get you—the transition, yes——

Ms. WILLIAMS [continuing]. Process easier—the transition easier.

Senator KAINE. That is good advice for others. And Mr. Chairman, could I ask one more question of Dr. Wight. We have had two really tough situations in Virginia in recent years. One, when I was Governor, a tragic shooting at Virginia Tech, and then recently a tragic shooting on the University of Virginia campus.

In both instances, there is some differences, and I don't want to make them sound exactly similar when they are not. But in both instances, the individuals who carried out these grievous crimes had tough high school years but had found supports in high school where they were able to be successful, successful students, successful athletes.

But then when they went to college, it was like none of that information that helped them succeed in the high school setting, it is like none of it went to the university setting.

In each instance, and we are still learning more about the University of Virginia situation, it seems like there was sort of a downward spiral, and maybe partly because they didn't have the support services surrounding them that knew their situation and knew how to help them succeed when they were in high school.

The RISE Act, which you all have introduced, would take, if somebody has an IEP, it would take that information from high school and not just make it easier for them to continue it in a university setting, but it would also transfer the knowledge about how to help this young person succeed to the college setting.

But how do you deal with that in your institution? This coming into a place where you are brand new and it is all you were expecting after 3 months to be an independent adult, make good choices, and maybe you have a past history that doesn't really—it is not—it is not made known to anybody on campus.

How do you help students in that transition at Xavier?

Dr. WRIGHT. Sure. So there is peer to peer training that we conduct so that the freshmen are paired with what we call peer deans, who are upper class students who help connect them to not only the social side of university life, but also those resources that will help them navigate the university.

We also think about those spaces where students are going and try to marry. So we know that students are going to see our campus ministry office, right. So training those folks to be able to help identify when they hear things, get them the counseling.

Similarly doing that same work in the classroom because sometimes faculty will interact with students, and they will see something in a report that they have written.

Or they will come to them, and they will say, I missed class today because of x. Or they will also let us know when they start to see things that are different. But I do think that the other—one of the most important things that we have been doing is really engaging our students' parents.

We want to respect them as full adults, but we also recognize that we can't do it without a full support system for them. And so working with those parents will oftentimes get us information that we didn't know that will then help us connect with their previous therapist.

Senator KAINE. Thank you. Thank you for that. I appreciate your letting me go over.

The CHAIRMAN. Thank you, Senator Kaine.

Senator Cassidy.

Senator CASSIDY. Dr. Wright, just to follow-up the kind of same thread as did Senator Kaine, and I think this is more for the audience watching so I just want you to kind of document by your testimony, if somebody does have an IEP as in a high school and they are trying to transfer to Xavier or another university, are you able to access that information at all? Can you access it even though

there is difficulty in terms of utilizing or using that information. Can you comment on that, please?

Dr. WRIGHT. We can't access it unless they give it to us. So they have to bring it to us. And then when they bring it to us, even if it is outdated, what we will do is provisionally provide those accommodations and set them up with a coordinated care plan to get them the evaluations that they need.

But unless they bring it to us, we don't have access to that, because in our admissions process, we are not allowed to ask them information about their mental health. Doctor——

Dr. WEISS. I was just going to add, and what you I think demonstrated so beautifully, is that when there is a mental health team involved with a high school student that is going to be transitioning to college or to a job, whatever they want we are very aware of what is going on in the senior year of high school.

We are sort of anticipating and preparing ahead of time of where they are planning on going, the application process. I have had to read a lot of personal statements for college applications.

We have already identified the key players in their new community. Whether it is a—they need a first episode program in their community. We have already reached out to them. We don't have——

Senator CASSIDY. Sorry, excuse me. What you are telling me is a best practice is that the high school counselor would then be seeking a HIPPA form release that she or he could send the information to the college, and the college could just again continue that sort of enveloping we are going to support you?

Dr. WEISS. Yes.

Dr. WRIGHT. Correct.

Senator CASSIDY. Do you have a sense of——

Dr. WEISS. You can be clear about what——

Senator CASSIDY. Do you have a sense of how often this best practice is actually implemented?

Dr. WRIGHT. Very little.

Dr. WEISS. Very little. I mean, it is——

Senator CASSIDY. Is it not implemented well or implemented so little, is that the problem with the university or is that the problem of the high school? Or what is going on here?

Dr. WRIGHT. I think that there is many, many things going on depending on what the situation is that you are dealing with. Via if it is an academic disability, then it would be——

Senator CASSIDY. But we are speaking specifically of mental health.

Dr. WEISS. Mental health.

Senator CASSIDY. Now, by the way, our RISE Act, if you have dyslexia, that doesn't change with lifetime. Forever you are dyslexic.

Dr. WEISS. Right.

Senator CASSIDY. That is easily taken over.

Dr. WEISS. Right.

Senator CASSIDY. Mental health is obviously a different issue.

Dr. WEISS. Right.

Senator CASSIDY. Again, if you had to tell us what is the problem between the person who is helping someone like Ms. Williams, sending that information to the college which she chooses to attend, and then that seamlessly moving into the counseling that she needs. Because if not, it ends up with the tragic consequences that Senator Kaine just referred to. What is the problem there? What can we do?

Dr. WEISS. Coordinating care from both sides.

Senator CASSIDY. Yes, ma'am, I get that. But what is the——

Dr. WEISS. People are answering the phones——

Senator CASSIDY [continuing]. Mechanism where we forced that marriage, if you will. It sounds like it is just not happening, and it sounds like it is just not happening because, it is a too strong to say, a lack of effort? Dr. Hoover.

Dr. HOOVER. Well, I would just say that we have to have some protections in place for health care privacy and——

Senator CASSIDY. But signing a HIPPA form would be——

Dr. HOOVER. That is exactly right. So we need to educate our young people as they transition to adulthood about their privacy rights and how to sign a HIPPA form.

Senator CASSIDY [continuing]. Because that really should be. I am a health care doctor——

Dr. HOOVER. Yes.

Senator CASSIDY. If somebody comes to me and I know they are moving to another state, I say, listen, I need to send your records to Mississippi and I need you to sign this form. I don't think it is incumbent upon the patient to understand that there is a form which she needs to sign.

Dr. HOOVER. But it is incumbent upon them to understand whether they would wish to. A lot of college students, one of the biggest hindrances of college students to actually having the—to actually getting services is because they don't necessarily know or want those services when they get to college.

Senator CASSIDY. But we are talking about something different. What we are talking about, because you and Dr. Wright, I think, spoke of, and Dr. Weiss spoke of proactively reaching out.

But that suggests that they have been informed that there is an issue. Now, I will say that the nice thing about somebody being 17 or 18, mama is still there.

Dr. WRIGHT. Correct.

Senator CASSIDY. I find that mamas are—like we couldn't live without them.

[Laughter.]

Senator CASSIDY. But she can come in and make sure, dear, I know that you need to sign this form, and I am going to sign it with you if you are a minor, and we are going to send those records. I am not sure I will accept the excuse that the student is unaware. Yes, that is true——

Dr. HOOVER. Not an excuse. I just think they need to be educated and I wholeheartedly agree.

Senator CASSIDY. But the initial sending of that record should be incumbent upon the guidance counselor or the social worker or whomever.

Dr. HOOVER. With the permission of the family, absolutely.

Senator CASSIDY. Exactly. I think what is not—what I am pushing, but what I am not quite sure I am receiving a yes that is true from, is there a problem, is there a lack of follow through on the behalf of the typical high school guidance counselor or social worker to trigger that?

Dr. HOOVER. Yes.

Dr. WEISS. Yes.

Senator CASSIDY. Okay. Now, is there likewise a sufficient—insufficient pull through, the university gets it and what do we do with it? Oh, that is great, put it in the file.

Dr. HOOVER. Yes.

Dr. WEISS. Yes.

Senator CASSIDY. As opposed to we are going to jump on this and make sure it doesn't happen?

Dr. WEISS. Yes.

Dr. HOOVER. There is often a requirement for reassessment, which as you alluded to earlier, is often completely unnecessary.

Dr. WEISS. Right.

Senator CASSIDY. Right. Our RISE Act addresses some of this.

Dr. HOOVER. Correct.

Senator CASSIDY. By this, I hope all my colleagues now will claim co-sponsors. But there is also, beyond Federal law, there is the lack of awareness in the high school and the university as to their respective roles.

Dr. WRIGHT. Correct. Senator, it is skill versus will, can we or will we. And I—can we? Absolutely, we can. But I do think that we sometimes hide behind policies, that will limit what we will do.

Senator CASSIDY. No, I totally get you, Dr. Wright. Oh, my gosh, people retreat because they are just so scared of their shadow, and they use that as an excuse.

Dr. WRIGHT. Right.

Senator CASSIDY. It is an incredible frustration of mine.

Dr. WRIGHT. Right. But I do think the RISE Act would help provide some Federal guidance on what we should be doing. And so——

Senator CASSIDY. But it is more than that, and I don't quite know what it is—it is probably——

Dr. WRIGHT. I think clinically if you are a clinically astute therapist with a high schooler, then you should be talking about these things. And it shouldn't be the day before you go, oh, let's send your mental health information.

It should be this whole transition and what is going to happen to make them feel safe and comfortable with like continuing their mental health care in the next phase of their life.

Senator CASSIDY. I will say, on the Federal level, there are some times that we can do best practices and we judge different organizations by best practices. And can you do an audit of your charts and see how many X, Y and Z?

I just say that for my colleagues, for us to start thinking about. I am out of time. I actually had other questions for you all, but I will submit those for the records, particularly for you, Dr. Weiss, as regards to how you are using the wraparound services and the need to augment Medicaid, which seems—just seems crazy. But we will get back to you. We will send you the letter for the record. Thank you.

The CHAIRMAN. Thank you, Senator Cassidy. And I will, I know we have to wrap up soon, but I will exercise a Chairman's prerogative by just adding maybe one more question for Brooklyn Williams.

But to our three doctors, if you can each, if you want to, provide anything else for the record that you hope you would—we have on the record, in 30 to 1—30 seconds to 1 minute each, if you can do that. This is kind of a quick lightning round before I will wrap up with Brooklyn, and then we will do our closings.

Dr. HOOVER. Glad to. So the one thing that I want to emphasize is that while we do need to invest in child mental health specialists and increase the numbers of counselors in schools, psychologists, etcetera, we really do need to make it that every adult and peer has education and training to support mental health.

That can be through things like mental health first aid and youth mental health first aid. There is also a free, federally funded mental health training for all educators called Classroom Well-Being Information and Strategies for educators or classroom wise.

We have many tools at our fingertips to train everybody in the system, and that would include in mental health literacy in the K through 12 curriculum. It can't rely—we can't rely solely on mental health specialists to cure our way out of this mental health crisis.

The CHAIRMAN. Thanks, Dr. Hoover.

Dr. Wright.

Dr. WRIGHT. I also want to echo Dr. Hoover in the need for mental health first aid. As someone who has sat and attended far too many funerals of students over the course of my career who had bright, brilliant futures but they weren't able to see that, this is an important conversation, and I am so grateful to the Committee for engaging in it.

But we also need to recognize that teacher preparation should involve a certain level of understanding how to navigate these spaces because they are the front line. So, thank you.

The CHAIRMAN. Thank you. Thank you, Dr. Wright.

Dr. Weiss.

Dr. WEISS. I echo as well and think that this mental health first stage should also include specific and more severe illnesses and not

just be a generic approach, because dealing with some of these more misunderstood mental health conditions can be very challenging for someone that doesn't have the background.

I just want to stress that while we talk about early intervention, we have to think about early detection and beyond schools, like to the communities.

The CHAIRMAN. Doctor, thanks very much. I am told Senator Kaine, you had something you wanted to say.

Senator KAINE. If I could just quick, and this is back to Senator Cassidy, this point on best practices. A university probably wouldn't want to try to get a student's medical record before the student was admitted because the student and family might wonder, well, maybe they will turn me down if they see something in my metal record they don't like.

But once a university admits a student the first letter that goes out is, hey, you have been admitted and here is the deposit you have to put down, and it has a whole lot of other information in it.

That letter from a college could say, we can help provide services on day one that will help your students succeed if we know as much as we can about what services help the students succeed in high school, if you will fill out this HIPPA form and send it back to us, we can get the schools full record, not just the transcript, but the full record so we can do that.

There are—the RISE Act is a really good one. But I also think there is best practices at that moment. Everybody is going to eagerly devour that letter, you are in and here is the deposit, but here is information, and that is a good moment to have that discussion.

I just kind of wanted to put that on the record for anybody from colleges that might be listening to this hearing.

The CHAIRMAN. Good point. Well, Brooklyn, you are going to be the last answer of the hearing. But I want to particularly thank you for not only being here. That is difficult enough. I could never do what you are doing when I was your age. Not even close.

But also, as much as it is inspiring to have you here and to hear your testimony, and to listen to the answers to questions, your story, what you have had to overcome personally is not just inspiring to people here but will inspire countless young people across the country. So we want to commend you for that.

I guess sometimes we don't often—often we don't listen enough here in Washington. We don't take enough time to hear the perspectives of young people. So I guess just by way of conclusion, what was your hope that we would hear? What point do you want to make before we conclude?

Ms. WILLIAMS. I would say just like try to take advantage of the young people that want to come and work with you guys, and just try to get them to reach out to the people around their age more because talking to people that are around your age is a lot I would say easier than trying to talk to people that have not like grown up the same way you have.

There is a lot of different experiences from when I would say when everyone here is like younger than whenever, like me now, like being a 17 year old in 2022. I would say just having more like ears and having the constant communication is very beneficial.

Without that, I feel like there is a lot—there would be a lot less good in what we are trying to accomplish. And I just wanted to say thank you for letting me talk among these doctors and all of you very insightful, like professional people.

It is just a really nice experience, and I am eternally grateful.

The CHAIRMAN. Brooklyn, thanks so much. We are honored by your presence as we are by all of our witnesses. I will have a closing statement and then I will turn to Ranking Member Cassidy for his. We know that in today's hearing we heard very, very powerful testimony about how to address the crisis in adolescent mental health and set our Nation's young people up for success in college and in life.

We also discussed creating systems of comprehensive mental health support in schools and communities to identify and respond to unprecedented mental health needs among our young people.

We also talked about gaps in the continuum of mental health care that must be filled through care integration in health care, and health workforce development, and a greater variety of timely care options. Long before the pandemic, there was a significant rise in mental health conditions among our Nation's young people.

Their mental health challenges have only been exacerbated by isolation and stress in recent years. Too many of our young people are not even able to show up as their full selves to fully enjoy the many experiences that make high school and college special.

Too often they don't have that opportunity to perform at their best and to achieve meaningful goals. Young people across our Country have unbounded potential and their whole lives ahead of them, and yet suicide is the second leading cause of death among people ages 10 to 14, and the third leading cause of death among young people ages 15 to 24.

We can't accept this. We must do more. We must do more here in Washington and across the country to help get young people the support they need. Congress must continue to support successful programs and legislation like those we have talked about today.

I look forward to working with my colleagues to achieve that, and to make sure that young people have the future that they deserve. So I will turn to Ranking Member Cassidy for his closing remarks.

Senator CASSIDY. Very briefly. Thank you all. What a great conference. In one sense, oh my gosh, there is so much to do. But there are tangible things that can be done that came out of this.

This room, as your example, of youth groups, peer to peer, if you will, helping others. The whole conversation regarding pre-authorization and how that can be better. And the whole idea that maybe we get to have Medicaid provide those sorts of services, those kind of coordination services, that therefore the SAMHSA grant would not be used for a lower calling, if you will, but could be a higher level of service.

Dr. Wright, thank you so much for Xavier doing best practices. Dr. Weiss too as regards how to take a child who is leaving high school in those 3 months later enrolling. Dr. Hoover, you have kind of seen the whole spectrum.

Thank you all. I think what we learned from this is a set of—a set of measures that, if taken, can make the situation better. And there is nothing more we could have asked for from this hearing. Thank you once more.

The CHAIRMAN. Thank you, Ranking Member Cassidy, and thanks for your work in helping us arrange this hearing.

I wanted to first, before we conclude also, in addition to thanking each of our witnesses for their testimony and their presence here today, I also want to ask unanimous consent to add two statements to the record. And I will describe them.

The first is a statement from the Children's Hospital Association on the need to ensure children and adolescents receive the mental and behavioral health services they need to prepare them for healthy, young adulthood.

The second is an excerpt from the 2020 National Survey on Drug Use and Health that includes current statistics on substance use, mental health, and treatment among adolescents.

So ordered that they are made part of the record.

[The information referred to can be found on page 49:]

The CHAIRMAN. If any Senators have additional questions for the witnesses or statements to be added, the hearing record will be kept open for 7 days until next Wednesday, December the 7th.

Thank you all for participating. This concludes today's hearing.

ADDITIONAL MATERIAL

EXCERPT FROM THE 2020 NATIONAL SURVEY ON DRUG USE AND HEALTH

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Table 11.1A Settings Where Mental Health Services Were Received in Past Year: Among People Aged 12 to 17; Numbers in Thousands, 2002-2020

Setting Where Mental Health Service Was Received	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
SPECIALTY MENTAL HEALTH SERVICE[1]	2,898	3,065	3,348	3,362	3,255	3,104	3,129	2,925	2,920	3,101	3,118	3,341	3,369	3,253	3,598	3,646	3,901	4,088	*4,246*
Outpatient	2,662	2,795	3,015	3,048	2,931	2,787	2,837	2,650	2,635	2,842	2,846	3,064	3,110	2,958	3,239	3,328	3,547	3,747	*4,088*
Private Therapist, Psychologist, Psychiatrist, Social Worker, or Counselor	2,254	2,347	2,523	2,573	2,416	2,365	2,408	2,296	2,265	2,409	2,427	2,572	2,698	2,532	2,819	2,908	3,080	3,213	*3,491*
Mental Health Clinic or Center	611	635	716	657	587	583	567	537	547	547	610	731	760	792	929	995	977	1,169	*1,187*
Partial Day Hospital or Day Treatment Program	440	425	439	449	471	416	374	340	362	393	431	477	467	455	489	505	484	517	*354*
In-Home Therapist, Counselor, or Family Preservation Worker	693	656	762	731	719	707	716	657	674	767	776	787	836	830	845	840	951	1,091	*939*
Inpatient or Residential[1]	509	542	629	619	596	581	539	524	531	526	547	574	606	642	737	708	683	701	*510*
Hospital	422	467	515	529	516	511	469	440	447	438	463	504	547	588	666	622	608	618	*429*
Residential Treatment Center	224	233	299	229	225	199	198	213	217	240	238	206	252	271	311	318	300	293	*277*
NONSPECIALTY MENTAL HEALTH SERVICE[2]	nc	nc	nc	nc	nc	nc	nc	3,430	3,465	3,463	3,649	3,634	3,736	3,691	3,732	3,810	3,977	4,371	*3,651*
Education[2,3]	nc	nc	nc	nc	nc	nc	nc	2,931	2,957	2,920	3,157	3,147	3,229	3,206	3,193	3,231	3,444	3,727	*3,136*
School Social Worker, School Psychologist, or School Counselor	nc	nc	nc	nc	nc	nc	nc	2,286	2,214	2,188	2,389	2,284	2,379	2,239	2,278	2,249	2,395	2,698	*2,354*
Special School or Program within a Regular School for Students with Emotional or Behavioral Problems	nc	nc	nc	nc	nc	nc	nc	975	1,054	1,063	1,142	1,218	1,207	1,357	1,319	1,345	1,461	1,477	*1,061*
General Medicine																			
Pediatrician or Other Family Doctor	657	732	840	810	694	692	710	605	601	619	629	686	700	668	708	805	767	902	*762*
Juvenile Justice																			
Juvenile Detention Center, Prison, or Jail	--	--	--	--	--	--	--	109	80	103	83	59	63	53	53	45	48	49	*22*
Child Welfare																			
Foster Care or Therapeutic Foster Care	157	179	158	143	129	114	118	92	108	140	96	99	92	79	108	92	94	97	*66*
SPECIALTY MENTAL HEALTH SERVICES AND EDUCATION, GENERAL MEDICINE OR CHILD WELFARE SERVICES[1,2,3]	nc	nc	nc	nc	nc	nc	nc	1,226	1,283	1,328	1,397	1,490	1,457	1,408	1,513	1,615	1,706	1,910	*1,678*

* = low precision; -- = not available; da = does not apply; nc = not comparable due to methodological changes; nr = not reported due to measurement issues.

NOTE: Estimates in the 2020 column are italicized to indicate caution should be used when comparing estimates between 2020 and prior years because of methodological changes for 2020. Due to these changes, significance testing between 2020 and prior years was not performed. See the *2020 National Survey on Drug Use and Health: Methodological Summary and Definitions* for details.

NOTE: Some 2006 to 2010 estimates may differ from previously published estimates due to updates (see Chapter 3 of the *2020 National Survey on Drug Use and Health: Methodological Summary and Definitions*).

NOTE: Mental health services for people aged 12 to 17 includes treatment/counseling for emotional or behavioral problems not caused by drug or alcohol use. Respondents with unknown mental health service information were excluded. Questions on virtual services were added in Quarter 4 of 2020. Estimates in this table do not include data from these questions. See the *2020 National Survey on Drug Use and Health: Methodological Summary and Definitions* for details.

NOTE: Respondents could indicate multiple service settings; thus, the response categories are not mutually exclusive.

[1] Because of revisions in 2013 to Specialty Mental Health Service estimates, these 2002 to 2012 estimates may differ from estimates published prior to the 2013 NSDUH.

[2] Because of revisions in 2009 to the questions on the Source of Youth Mental Health Education Services, these estimates are not comparable with the education services estimates published prior to the 2009 NSDUH.

[3] Respondents who did not report their school enrollment status, who reported not being enrolled in school in the past 12 months, or who reported being home-schooled were not asked about receipt of mental health services from this setting; however, respondents who reported not being enrolled in school in the past 12 months were classified as not having received mental health services from this setting.

Definitions: Measures and terms are defined in Appendix A.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2019, and Quarters 1 and 4, 2020.

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Table 11.1B Settings Where Mental Health Services Were Received in Past Year: Among People Aged 12 to 17; Percentages, 2002-2020

Setting Where Mental Health Service Was Received	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
SPECIALTY MENTAL HEALTH SERVICE[1]	11.8	12.4	13.4	13.4	13.0	12.4	12.7	12.0	12.1	12.6	12.7	13.6	13.7	13.3	14.7	14.8	16.0	16.7	*17.3*
Outpatient	10.8	11.3	12.1	12.1	11.7	11.2	11.5	10.9	10.9	11.5	11.5	12.5	12.7	12.0	13.2	13.6	14.5	15.3	*16.6*
Private Therapist, Psychologist, Psychiatrist, Social Worker, or Counselor	9.2	9.5	10.1	10.2	9.6	9.5	9.8	9.4	9.4	9.8	9.8	10.5	11.0	10.3	11.5	11.8	12.6	13.1	*14.2*
Mental Health Clinic or Center	2.5	2.6	2.9	2.6	2.3	2.3	2.3	2.2	2.3	2.2	2.5	3.0	3.1	3.2	3.8	4.0	4.0	4.8	*4.8*
Partial Day Hospital or Day Treatment Program	1.8	1.7	1.8	1.8	1.9	1.7	1.5	1.4	1.5	1.6	1.7	1.9	1.9	1.8	2.0	2.0	2.0	2.1	*1.4*
In-Home Therapist, Counselor, or Family Preservation Worker	2.8	2.6	3.0	2.9	2.9	2.8	2.9	2.7	2.8	3.1	3.1	3.2	3.4	3.4	3.4	3.4	3.9	4.5	*3.8*
Inpatient or Residential[1]	2.1	2.2	2.5	2.5	2.4	2.3	2.2	2.1	2.2	2.1	2.2	2.3	2.5	2.6	3.0	2.9	2.8	2.9	*2.1*
Hospital	1.7	1.9	2.1	2.1	2.0	2.0	1.9	1.8	1.8	1.8	1.9	2.0	2.2	2.4	2.7	2.5	2.5	2.5	*1.7*
Residential Treatment Center	0.9	0.9	1.2	0.9	0.9	0.8	0.8	0.9	0.9	1.0	1.0	0.8	1.0	1.1	1.3	1.3	1.2	1.2	*1.1*
NONSPECIALTY MENTAL HEALTH SERVICE[2]	nc	nc	nc	nc	nc	nc	nc	14.2	14.5	14.2	15.0	15.0	15.4	15.2	15.4	15.7	16.5	18.1	*15.0*
Education[2,3]	nc	nc	nc	nc	nc	nc	nc	12.1	12.4	11.9	12.9	13.0	13.2	13.2	13.1	13.3	14.2	15.4	*12.8*
School Social Worker, School Psychologist, or School Counselor	nc	nc	nc	nc	nc	nc	nc	9.4	9.2	8.9	9.7	9.4	9.7	9.2	9.3	9.2	9.9	11.1	*9.6*
Special School or Program within a Regular School for Students with Emotional or Behavioral Problems	nc	nc	nc	nc	nc	nc	nc	4.0	4.4	4.3	4.7	5.0	4.9	5.6	5.4	5.5	6.0	6.1	*4.3*
General Medicine																			
Pediatrician or Other Family Doctor	2.7	2.9	3.4	3.2	2.8	2.8	2.9	2.5	2.5	2.5	2.5	2.8	2.9	2.7	2.9	3.3	3.1	3.7	*3.1*
Juvenile Justice																			
Juvenile Detention Center, Prison, or Jail	--	--	--	--	--	--	--	0.4	0.3	0.4	0.3	0.2	0.3	0.2	0.2	0.2	0.2	0.2	*0.1*
Child Welfare																			
Foster Care or Therapeutic Foster Care	0.6	0.7	0.6	0.6	0.5	0.5	0.5	0.4	0.4	0.6	0.4	0.4	0.4	0.3	0.4	0.4	0.4	0.4	*0.3*
SPECIALTY MENTAL HEALTH SERVICES AND EDUCATION, GENERAL MEDICINE OR CHILD WELFARE SERVICES[2,3]	nc	nc	nc	nc	nc	nc	nc	5.0	5.3	5.4	5.7	6.1	5.9	5.7	6.2	6.6	7.0	7.8	*6.8*

* = low precision; -- = not available; da = does not apply; nc = not comparable due to methodological changes; nr = not reported due to measurement issues.

NOTE: Estimates in the 2020 column are italicized to indicate caution should be used when comparing estimates between 2020 and prior years because of methodological changes for 2020. Due to these changes, significance testing between 2020 and prior years was not performed. See the *2020 National Survey on Drug Use and Health: Methodological Summary and Definitions* for details.

NOTE: Some 2006 to 2010 estimates may differ from previously published estimates due to updates (see Chapter 3 of the *2020 National Survey on Drug Use and Health: Methodological Summary and Definitions*).

NOTE: Mental health services for people aged 12 to 17 includes treatment/counseling for emotional or behavioral problems not caused by drug or alcohol use. Respondents with unknown mental health service information were excluded. Questions on virtual services were added in Quarter 4 of 2020. Estimates in this table do not include data from these questions. See the *2020 National Survey on Drug Use and Health: Methodological Summary and Definitions* for details.

NOTE: Respondents could indicate multiple service settings; thus, the response categories are not mutually exclusive.

[1] Because of revisions in 2013 to Specialty Mental Health Service estimates, these 2002 to 2012 estimates may differ from estimates published prior to the 2013 NSDUH.

[2] Because of revisions in 2009 to the questions on the Source of Youth Mental Health Education Services, these estimates are not comparable with the education services estimates published prior to the 2009 NSDUH.

[3] Respondents who did not report their school enrollment status, who reported not being enrolled in school in the past 12 months, or who reported being home-schooled were not asked about receipt of mental health services from this setting; however, respondents who reported not being enrolled in school in the past 12 months were classified as not having received mental health services from this setting.

Definitions: Measures and terms are defined in Appendix A.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2019, and Quarters 1 and 4, 2020.

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Table 11.2A Major Depressive Episode in Past Year: Among People Aged 12 to 17; by Demographic Characteristics, Numbers in Thousands, 2004-2020

Demographic Characteristic	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
TOTAL	2,225	2,191	1,970	2,016	2,027	1,954	1,911	2,011	2,213	2,587	2,751	3,031	3,089	3,214	3,482	3,783	*4,131*
AGE GROUP																	
12-13	445	417	383	337	366	330	330	312	420	470	548	587	548	516	632	816	*902*
14-15	783	811	684	705	706	741	706	710	844	1,025	986	1,163	1,115	1,200	1,250	1,341	*1,533*
16-17	997	964	902	974	955	883	876	989	950	1,091	1,217	1,281	1,427	1,498	1,600	1,626	*1,696*
GENDER																	
Male	637	571	539	586	540	577	536	566	581	657	710	725	786	845	946	1,076	*1,135*
Female	1,588	1,620	1,431	1,430	1,487	1,377	1,375	1,446	1,632	1,930	2,042	2,306	2,303	2,369	2,537	2,708	*2,996*
HISPANIC ORIGIN AND RACE																	
Not Hispanic or Latino	1,848	1,802	1,614	1,691	1,681	1,594	1,537	1,586	1,648	1,970	2,123	2,323	2,366	2,419	2,601	2,755	*3,176*
White	1,413	1,390	1,220	1,284	1,266	1,180	1,186	1,167	1,231	1,449	1,578	1,742	1,781	1,785	1,905	1,975	*2,330*
Black or African American	287	288	245	292	261	285	236	238	269	289	306	302	301	313	334	367	*392*
AIAN	13	10	12	7	13	9	10	15	7	7	11	*	16	24	23	*20*	*
NHOPI	*	*	*	*	*	*	1	*	*	*	*	*	*	*	*	*	*
Asian	82	63	77	66	73	73	57	90	49	123	124	118	152	145	189	190	*252*
Two or More Races	51	41	52	41	59	41	48	75	81	95	93	121	109	138	137	189	*179*
Hispanic or Latino	377	389	356	325	347	360	374	425	566	617	628	708	724	795	882	1,028	*936*

* = low precision; -- = not available; da = does not apply; nc = not comparable due to methodological changes; nr = not reported due to measurement issues.
NOTE: Estimates in the 2020 column are italicized to indicate caution should be used when comparing estimates between 2020 and prior years because of methodological changes for 2020. Due to these changes, significance testing between 2020 and prior years was not performed. See the *2020 National Survey on Drug Use and Health: Methodological Summary and Definitions* for details.
NOTE: Some 2006 to 2010 estimates may differ from previously published estimates due to updates (see Chapter 3 of the *2020 National Survey on Drug Use and Health: Methodological Summary and Definitions*).
NOTE: Respondents with unknown past year Major Depressive Episode (MDE) data were excluded.

Definitions: Measures and terms are defined in Appendix A.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2004-2019, and Quarters 1 and 4, 2020.

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Table 11.2B Major Depressive Episode in Past Year: Among People Aged 12 to 17; by Demographic Characteristics, Percentages, 2004-2020

Demographic Characteristic	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
TOTAL	9.0	8.8	7.9	8.2	8.3	8.1	8.0	8.2	9.1	10.7	11.4	12.5	12.8	13.3	14.4	15.7	*17.0*
AGE GROUP																	
12-13	5.4	5.2	4.9	4.3	4.9	4.6	4.3	4.1	5.4	6.1	7.2	7.8	7.3	6.9	8.4	10.5	*11.2*
14-15	9.2	9.5	7.9	8.4	8.5	8.8	9.0	8.6	10.2	12.4	11.9	13.8	13.3	14.5	15.3	16.4	*18.2*
16-17	12.3	11.5	10.7	11.5	11.2	10.4	10.6	11.7	11.4	13.2	14.6	15.5	17.2	17.7	19.0	20.1	*21.9*
GENDER																	
Male	5.0	4.5	4.2	4.6	4.3	4.7	4.4	4.5	4.7	5.3	5.7	5.8	6.4	6.8	7.7	8.8	*9.2*
Female	13.1	13.3	11.8	11.9	12.5	11.7	11.9	12.1	13.7	16.2	17.3	19.5	19.4	20.0	21.5	23.0	*25.2*
HISPANIC ORIGIN AND RACE																	
Not Hispanic or Latino	8.9	8.7	7.9	8.4	8.5	8.2	8.1	8.3	8.7	10.4	11.3	12.5	12.8	13.1	14.2	15.2	*17.5*
White	9.2	9.1	8.2	8.7	8.8	8.4	8.6	8.6	9.1	10.9	12.0	13.4	13.8	14.0	15.1	15.9	*18.7*
Black or African American	7.7	7.6	6.4	7.8	7.1	7.9	6.8	7.0	7.9	8.6	9.1	9.0	9.1	9.5	10.3	11.4	*12.9*
AIAN	7.8	6.1	9.3	4.6	10.1	7.5	7.4	11.4	5.2	4.5	6.9	*	11.5	16.3	15.2	12.2	*
NHOPI	*	*	*	*	*	*	1.8	*	*	*	*	*	*	*	*	*	*
Asian	8.3	6.0	7.7	6.6	7.7	7.6	5.5	7.6	4.2	10.2	10.4	9.7	11.9	11.3	13.6	15.1	*13.9*
Two or More Races	11.7	10.5	13.0	9.9	12.0	8.0	9.4	10.6	11.3	13.0	12.5	15.6	13.8	16.9	17.7	20.9	*29.9*
Hispanic or Latino	9.1	9.1	8.0	7.1	7.5	7.7	7.8	8.1	10.5	11.4	11.5	12.6	12.7	13.8	15.1	17.3	*15.7*

* = low precision; -- = not available; da = does not apply; nc = not comparable due to methodological changes; nr = not reported due to measurement issues.

NOTE: Estimates in the 2020 column are italicized to indicate caution should be used when comparing estimates between 2020 and prior years because of methodological changes for 2020. Due to these changes, significance testing between 2020 and prior years was not performed. See the *2020 National Survey on Drug Use and Health: Methodological Summary and Definitions* for details.

NOTE: Some 2006 to 2010 estimates may differ from previously published estimates due to updates (see Chapter 3 of the *2020 National Survey on Drug Use and Health: Methodological Summary and Definitions*).

NOTE: Respondents with unknown past year Major Depressive Episode (MDE) data were excluded.

Definitions: Measures and terms are defined in Appendix A.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2004-2019, and Quarters 1 and 4, 2020.

Table 11.3A Major Depressive Episode with Severe Impairment in Past Year: Among People Aged 12 to 17; by Demographic Characteristics, Numbers in Thousands, 2006-2020

Demographic Characteristic	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
TOTAL	1,358	1,371	1,460	1,404	1,350	1,388	1,544	1,868	1,990	2,129	2,168	2,265	2,423	2,671	*2,919*
AGE GROUP															
12-13	211	200	239	235	232	218	285	314	375	388	354	332	382	530	*641*
14-15	518	500	505	521	479	487	590	752	707	826	789	861	891	970	*1,094*
16-17	629	671	716	648	639	683	669	801	909	915	1,025	1,072	1,150	1,171	*1,184*
GENDER															
Male	335	386	359	391	395	397	373	435	461	477	539	581	628	736	*732*
Female	1,023	986	1,101	1,013	954	991	1,172	1,432	1,529	1,652	1,629	1,684	1,795	1,935	*2,187*
HISPANIC ORIGIN AND RACE															
Not Hispanic or Latino	1,118	1,141	1,226	1,150	1,093	1,113	1,152	1,425	1,540	1,651	1,703	1,694	1,841	1,981	*2,230*
White	871	873	944	858	853	799	883	1,046	1,167	1,258	1,290	1,256	1,354	1,415	*1,616*
Black or African American	150	193	171	204	157	183	164	207	214	198	196	233	225	256	*294*
AIAN	9	4	8	5	7	13	4	6	8	*	8	6	*	19	*
NHOPI	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Asian	54	39	44	48	44	60	30	98	80	67	118	101	127	142	*186*
Two or More Races	32	32	50	31	30	57	64	61	66	98	86	89	109	134	*118*
Hispanic or Latino	240	230	233	254	257	275	392	442	450	477	465	571	582	690	*689*

* = low precision; -- = not available; da = does not apply; nc = not comparable due to methodological changes; nr = not reported due to measurement issues.
NOTE: Estimates in the 2020 column are italicized to indicate caution should be used when comparing estimates between 2020 and prior years because of methodological changes for 2020. Due to these changes, significance testing between 2020 and prior years was not performed. See the *2020 National Survey on Drug Use and Health: Methodological Summary and Definitions* for details.
NOTE: Some 2006 to 2010 estimates may differ from previously published estimates due to updates (see Chapter 3 of the *2020 National Survey on Drug Use and Health: Methodological Summary and Definitions*).
NOTE: Respondents with unknown past year Major Depressive Episode (MDE) data were excluded.
NOTE: Respondents with unknown impairment data were excluded.

Definitions: Measures and terms are defined in Appendix A.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2006-2019, and Quarters 1 and 4, 2020.

Table 11.3B Major Depressive Episode with Severe Impairment in Past Year: Among People Aged 12 to 17; by Demographic Characteristics, Percentages, 2006-2020

Demographic Characteristic	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
TOTAL	5.5	5.5	6.0	5.8	5.7	5.7	6.3	7.7	8.2	8.8	9.0	9.4	10.0	11.1	*12.0*
AGE GROUP															
12-13	2.7	2.5	3.2	3.2	3.0	2.8	3.7	4.1	4.9	5.1	4.7	4.4	5.1	6.8	*7.9*
14-15	6.0	6.0	6.1	6.2	6.1	5.9	7.1	9.1	8.5	9.8	9.4	10.4	10.9	11.9	*13.0*
16-17	7.5	7.9	8.4	7.7	7.7	8.1	8.0	9.7	10.9	11.1	12.4	12.7	13.7	14.5	*15.3*
GENDER															
Male	2.6	3.0	2.9	3.2	3.2	3.2	3.0	3.5	3.7	3.8	4.4	4.7	5.1	6.0	*5.9*
Female	8.4	8.2	9.3	8.6	8.2	8.3	9.8	12.0	13.0	14.0	13.7	14.2	15.2	16.5	*18.4*
HISPANIC ORIGIN AND RACE															
Not Hispanic or Latino	5.5	5.7	6.2	5.9	5.7	5.8	6.1	7.6	8.2	8.9	9.2	9.2	10.1	11.0	*12.3*
White	5.8	5.9	6.5	6.1	6.2	5.9	6.5	7.8	8.9	9.7	10.0	9.8	10.7	11.4	*13.0*
Black or African American	3.9	5.1	4.6	5.7	4.5	5.4	4.8	6.2	6.4	5.9	6.0	7.1	6.9	8.0	*9.7*
AIAN	6.6	2.6	6.5	4.3	5.4	9.8	2.6	3.8	4.9	*	5.7	3.9	*	11.5	*
NHOPI	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Asian	5.3	3.9	4.7	5.0	4.3	5.0	2.6	8.1	6.6	5.5	9.3	7.9	9.2	11.3	*10.3*
Two or More Races	8.0	7.8	10.2	6.0	5.9	8.1	9.0	8.4	8.9	12.6	10.9	10.9	14.2	14.9	*19.7*
Hispanic or Latino	5.4	5.1	5.1	5.4	5.4	5.2	7.3	8.2	8.2	8.5	8.2	9.9	10.0	11.7	*11.3*

* = low precision; -- = not available; da = does not apply; nc = not comparable due to methodological changes; nr = not reported due to measurement issues.
NOTE: Estimates in the 2020 column are italicized to indicate caution should be used when comparing estimates between 2020 and prior years because of methodological changes for 2020. Due to these changes, significance testing between 2020 and prior years was not performed. See the *2020 National Survey on Drug Use and Health: Methodological Summary and Definitions* for details.
NOTE: Some 2006 to 2010 estimates may differ from previously published estimates due to updates (see Chapter 3 of the *2020 National Survey on Drug Use and Health: Methodological Summary and Definitions*).
NOTE: Respondents with unknown past year Major Depressive Episode (MDE) data were excluded.
NOTE: Respondents with unknown impairment data were excluded.

Definitions: Measures and terms are defined in Appendix A.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2006-2019, and Quarters 1 and 4, 2020.

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Table 11.4A Receipt of Treatment for Depression in Past Year: Among People Aged 12 to 17 with Major Depressive Episode in Past Year; by Demographic Characteristics, Numbers in Thousands, 2004-2020

Demographic Characteristic	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
TOTAL	895	822	760	782	764	673	721	769	813	977	1,122	1,186	1,249	1,330	1,432	1,627	*1,710*
AGE GROUP																	
12-13	169	136	133	137	122	98	106	112	127	181	194	185	189	193	251	302	*
14-15	278	329	263	259	236	244	271	258	307	376	394	472	455	453	514	585	*629*
16-17	448	357	364	386	405	331	343	400	379	420	535	530	605	684	667	740	*675*
GENDER																	
Male	239	193	189	214	183	168	171	199	163	193	265	262	260	274	351	391	*448*
Female	656	629	571	568	581	505	549	570	650	784	857	924	989	1,056	1,081	1,236	*1,262*
HISPANIC ORIGIN AND RACE																	
Not Hispanic or Latino	756	700	634	691	658	555	577	645	642	753	918	936	1,008	1,072	1,100	1,251	*1,357*
White	633	544	502	545	545	444	487	482	500	598	723	702	799	847	870	985	*1,133*
Black or African American	82	113	70	116	85	67	54	97	90	83	123	127	102	110	115	130	*
AIAN	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
NHOPI	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Asian	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Two or More Races	*	*	*	*	*	*	*	*	*	*	*	55	*	62	48	83	*
Hispanic or Latino	139	122	126	91	105	118	144	125	171	224	204	251	241	258	332	376	*354*

* = low precision; -- = not available; da = does not apply; nc = not comparable due to methodological changes; nr = not reported due to measurement issues.
NOTE: Estimates in the 2020 column are italicized to indicate caution should be used when comparing estimates between 2020 and prior years because of methodological changes for 2020. Due to these changes, significance testing between 2020 and prior years was not performed. See the *2020 National Survey on Drug Use and Health: Methodological Summary and Definitions* for details.
NOTE: Some 2006 to 2010 estimates may differ from previously published estimates due to updates (see Chapter 3 of the *2020 National Survey on Drug Use and Health: Methodological Summary and Definitions*).
NOTE: Respondents with unknown past year treatment for depression data were excluded.
NOTE: Respondents with unknown past year Major Depressive Episode (MDE) data were excluded.

Definitions: Measures and terms are defined in Appendix A.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2004-2019, and Quarters 1 and 4, 2020.

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Table 11.4B Receipt of Treatment for Depression in Past Year: Among People Aged 12 to 17 with Major Depressive Episode in Past Year; by Demographic Characteristics, Percentages, 2004-2020

Demographic Characteristic	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
TOTAL	40.3	37.8	38.8	39.0	37.7	34.6	37.8	38.4	37.0	38.1	41.2	39.3	40.9	41.5	41.4	43.3	*41.6*
AGE GROUP																	
12-13	38.2	32.9	35.1	41.5	33.5	30.0	32.5	36.3	30.7	39.1	35.9	31.9	35.3	37.6	40.7	37.5	*
14-15	35.5	41.1	38.4	36.8	33.6	33.2	38.4	36.3	36.6	37.2	40.1	40.6	41.3	37.9	41.2	43.9	*41.5*
16-17	45.0	37.1	40.7	39.8	42.4	37.5	39.3	40.5	40.0	38.6	44.4	41.5	42.6	45.8	41.8	45.6	*40.0*
GENDER																	
Male	37.7	34.1	35.3	36.7	34.0	29.2	32.0	35.3	28.3	29.7	37.7	36.3	33.5	32.5	37.5	36.8	*39.7*
Female	41.3	39.0	40.2	40.0	39.1	36.9	40.1	39.5	40.1	40.9	42.4	40.3	43.4	44.8	42.9	45.8	*42.4*
HISPANIC ORIGIN AND RACE																	
Not Hispanic or Latino	41.0	39.0	39.5	41.1	39.3	35.0	37.6	40.7	39.0	38.5	43.5	40.5	42.9	44.4	42.6	45.7	*43.1*
White	44.9	39.3	41.3	42.7	43.1	37.7	41.1	41.4	40.7	41.6	46.1	40.6	45.1	47.5	46.1	50.3	*49.1*
Black or African American	28.9	39.3	29.1	39.7	32.4	23.9	23.0	41.0	33.5	28.6	40.6	42.0	34.5	35.1	34.6	35.6	*
AIAN	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
NHOPI	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Asian	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Two or More Races	*	*	*	*	*	*	*	*	*	*	*	46.7	*	44.8	34.8	44.4	*
Hispanic or Latino	36.8	31.8	35.9	28.2	30.4	33.0	38.4	29.4	30.8	36.9	33.1	35.5	34.1	32.7	37.9	36.8	*37.0*

* = low precision; -- = not available; da = does not apply; nc = not comparable due to methodological changes; nr = not reported due to measurement issues.
NOTE: Estimates in the 2020 column are italicized to indicate caution should be used when comparing estimates between 2020 and prior years because of methodological changes for 2020. Due to these changes, significance testing between 2020 and prior years was not performed. See the *2020 National Survey on Drug Use and Health: Methodological Summary and Definitions* for details.
NOTE: Some 2006 to 2010 estimates may differ from previously published estimates due to updates (see Chapter 3 of the *2020 National Survey on Drug Use and Health: Methodological Summary and Definitions*).
NOTE: Respondents with unknown past year treatment for depresion data were excluded.
NOTE: Respondents with unknown past year Major Depressive Episode (MDE) data were excluded.

Definitions: Measures and terms are defined in Appendix A.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2004-2019, and Quarters 1 and 4, 2020.

Table 11.5A Receipt of Treatment for Depression in Past Year: Among People Aged 12 to 17 with Major Depressive Episode with Severe Impairment in Past Year; by Demographic Characteristics, Numbers in Thousands, 2006-2020

Demographic Characteristic	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
TOTAL	627	601	622	542	554	602	633	832	882	945	1,001	1,074	1,133	1,321	*1,361*
AGE GROUP															
12-13	92	85	91	78	66	91	91	150	143	142	131	153	177	218	*
14-15	232	216	194	184	215	200	239	320	307	374	369	364	406	492	*521*
16-17	304	300	336	280	273	311	302	363	433	429	501	558	550	612	*527*
GENDER															
Male	134	154	132	132	132	147	127	157	189	206	208	208	274	300	*341*
Female	493	447	489	410	422	455	506	675	693	739	793	866	859	1,021	*1,020*
HISPANIC ORIGIN AND RACE															
Not Hispanic or Latino	535	534	550	443	448	502	506	645	725	755	827	868	882	1,018	*1,088*
White	432	439	461	352	380	379	403	504	572	563	668	679	695	800	*917*
Black or African American	53	72	65	58	42	82	56	72	99	97	71	97	90	108	*
AIAN	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
NHOPI	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Asian	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Two or More Races	*	*	*	*	*	*	*	*	*	*	*	*	*	63	*
Hispanic or Latino	92	67	72	99	106	100	127	187	158	190	174	206	251	304	*273*

* = low precision; -- = not available; da = does not apply; nc = not comparable due to methodological changes; nr = not reported due to measurement issues.
NOTE: Estimates in the 2020 column are italicized to indicate caution should be used when comparing estimates between 2020 and prior years because of methodological changes for 2020. Due to these changes, significance testing between 2020 and prior years was not performed. See the *2020 National Survey on Drug Use and Health: Methodological Summary and Definitions* for details.
NOTE: Some 2006 to 2010 estimates may differ from previously published estimates due to updates (see Chapter 3 of the *2020 National Survey on Drug Use and Health: Methodological Summary and Definitions*).
NOTE: Respondents with unknown past year treatment for depression data were excluded.
NOTE: Respondents with unknown past year Major Depressive Episode (MDE) data were excluded.
NOTE: Respondents with unknown impairment data were excluded.

Definitions: Measures and terms are defined in Appendix A.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2006-2019, and Quarters 1 and 4, 2020.

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Table 11.5B Receipt of Treatment for Depression in Past Year: Among People Aged 12 to 17 with Major Depressive Episode with Severe Impairment in Past Year; by Demographic Characteristics, Percentages, 2006-2020

Demographic Characteristic	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
TOTAL	46.5	43.9	42.6	38.8	41.1	43.5	41.0	45.0	44.7	44.6	46.7	47.5	46.9	49.7	*46.9*
AGE GROUP															
12-13	44.1	42.3	38.3	33.8	28.7	42.3	32.0	48.5	38.7	37.0	37.6	46.2	47.2	41.9	*
14-15	44.8	43.2	38.6	35.6	45.0	41.0	40.5	43.2	43.4	45.4	47.5	42.3	45.6	50.8	*48.1*
16-17	48.8	44.9	46.9	43.2	42.7	45.5	45.4	45.3	48.1	47.1	49.2	52.0	47.8	52.3	*44.8*
GENDER															
Male	40.1	40.2	36.9	34.0	33.4	37.3	34.4	36.4	41.2	43.1	39.0	35.8	43.7	41.2	*46.6*
Female	48.6	45.4	44.5	40.7	44.3	45.9	43.2	47.6	45.7	45.1	49.3	51.5	48.1	52.9	*47.0*
HISPANIC ORIGIN AND RACE															
Not Hispanic or Latino	48.0	46.8	44.9	38.7	41.1	45.2	43.9	45.6	47.3	46.0	48.9	51.3	48.1	51.7	*49.2*
White	49.8	50.4	48.9	41.1	44.5	47.4	45.7	48.6	49.2	45.0	52.1	54.1	51.6	57.0	*57.3*
Black or African American	35.5	37.4	38.0	28.9	26.9	44.6	34.4	34.9	46.9	48.8	37.1	41.6	40.1	42.3	*
AIAN	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
NHOPI	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Asian	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Two or More Races	*	*	*	*	*	*	*	*	*	*	*	*	*	47.3	*
Hispanic or Latino	39.4	29.4	30.8	39.3	41.3	36.4	32.6	43.1	35.6	40.0	38.4	36.1	43.2	44.0	*39.6*

* = low precision; -- = not available; da = does not apply; nc = not comparable due to methodological changes; nr = not reported due to measurement issues.
NOTE: Estimates in the 2020 column are italicized to indicate caution should be used when comparing estimates between 2020 and prior years because of methodological changes for 2020. Due to these changes, significance testing between 2020 and prior years was not performed. See the *2020 National Survey on Drug Use and Health: Methodological Summary and Definitions* for details.
NOTE: Some 2006 to 2010 estimates may differ from previously published estimates due to updates (see Chapter 3 of the *2020 National Survey on Drug Use and Health: Methodological Summary and Definitions*).
NOTE: Respondents with unknown past year treatment for depression data were excluded.
NOTE: Respondents with unknown past year Major Depressive Episode (MDE) data were excluded.
NOTE: Respondents with unknown impairment data were excluded.

Definitions: Measures and terms are defined in Appendix A.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2006-2019, and Quarters 1 and 4, 2020.

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Table 11.6A Substance Use in Past Year and Past Month: Among People Aged 12 to 17 with Major Depressive Episode in Past Year; Numbers in Thousands, 2004-2020

Substance	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
PAST YEAR USE																	
Illicit Drugs	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	955	979	942	1,138	1,207	*1,193*
Marijuana	601	553	483	473	485	472	481	523	547	664	664	675	751	724	878	930	*908*
Cocaine	66	73	64	69	61	43	46	54	53	28	41	34	35	37	35	29	*38*
Crack	15	12	16	17	12	9	9	11	7	2	11	*	4	2	0	10	*
Heroin	9	10	11	6	9	10	10	11	11	7	12	5	3	6	3	*	*
Hallucinogens	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	129	127	145	112	147	*132*
LSD	36	38	18	16	28	43	24	30	40	29	48	63	41	72	62	99	*89*
PCP	21	16	11	8	20	12	8	12	9	6	11	2	6	12	6	7	*
Ecstasy	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	45	59	47	46	60	*34*
Inhalants	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	193	159	143	178	235	*288*
Methamphetamine	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	14	6	14	8	10	*
Misuse of Prescription Psychotherapeutics	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	370	411	369	375	355	*229*
Pain Relievers	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	236	283	210	214	158	*94*
Stimulants	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	166	142	158	126	184	*115*
Tranquilizers or Sedatives	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	117	168	167	168	174	*108*
Tranquilizers	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	103	149	164	153	155	*96*
Sedatives	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	26	43	22	34	45	*12*
Benzodiazepines	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	96	142	154	145	149	*81*
Opioids	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	236	285	212	214	158	*94*
Central Nervous System Stimulants	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	181	164	173	158	200	*140*
Illicit Drugs Other Than Marijuana[1]	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	563	553	515	547	595	*552*
PAST MONTH USE																	
Alcohol	632	606	523	553	509	473	460	482	503	490	556	524	508	524	558	638	*673*
Binge Alcohol Use[2]	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	288	268	293	295	338	*254*
Heavy Alcohol Use	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	51	52	39	22	53	*49*
Cigarette Use	508	450	378	388	354	336	302	317	284	288	254	241	239	214	212	166	*110*
Daily Cigarette Use	171	116	102	96	75	70	59	81	61	46	45	55	27	25	23	14	*6*

* = low precision; -- = not available; da = does not apply; nc = not comparable due to methodological changes; nr = not reported due to measurement issues.
NOTE: Estimates in the 2020 column are italicized to indicate caution should be used when comparing estimates between 2020 and prior years because of methodological changes for 2020. Due to these changes, significance testing between 2020 and prior years was not performed. See the *2020 National Survey on Drug Use and Health: Methodological Summary and Definitions* for details.
NOTE: Some 2006 to 2010 estimates may differ from previously published estimates due to updates (see Chapter 3 of the *2020 National Survey on Drug Use and Health: Methodological Summary and Definitions*).
NOTE: Respondents with unknown past year Major Depressive Episode (MDE) data were excluded.

[1] Illicit Drugs Other Than Marijuana excludes respondents who used only marijuana but includes those who used marijuana in addition to other illicit drugs.
[2] Estimates of binge alcohol use include use by those who were heavy alcohol users.

Definitions: Measures and terms are defined in Appendix A.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2004-2019, and Quarters 1 and 4, 2020.

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Table 11.6B Substance Use in Past Year and Past Month: Among People Aged 12 to 17 with Major Depressive Episode in Past Year; Percentages, 2004-2020

Substance	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
PAST YEAR USE																	
Illicit Drugs	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	31.5	31.7	29.3	32.7	31.9	*28.6*
Marijuana	27.0	25.2	24.5	23.5	23.9	24.2	25.2	26.0	24.7	25.7	24.1	22.3	24.3	22.5	25.2	24.6	*22.0*
Cocaine	3.0	3.4	3.3	3.4	3.0	2.2	2.4	2.7	2.4	1.1	1.5	1.1	1.1	1.1	1.0	0.8	*0.9*
Crack	0.7	0.6	0.8	0.9	0.6	0.5	0.5	0.5	0.3	0.1	0.4	*	0.1	0.1	0.0	0.3	*
Heroin	0.4	0.4	0.5	0.3	0.4	0.5	0.5	0.5	0.5	0.3	0.4	0.2	0.1	0.2	0.1	*	*
Hallucinogens	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	4.2	4.1	4.5	3.2	3.9	*3.7*
LSD	1.6	1.7	0.9	0.8	1.4	2.2	1.2	1.5	1.8	1.1	1.8	2.1	1.3	2.2	1.8	2.6	*2.2*
PCP	0.9	0.7	0.6	0.4	1.0	0.6	0.4	0.6	0.4	0.2	0.4	0.1	0.2	0.4	0.2	0.2	*
Ecstasy	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	1.5	1.9	1.5	1.3	1.6	*0.8*
Inhalants	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	6.4	5.1	4.5	5.1	6.2	*7.0*
Methamphetamine	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	0.5	0.2	0.4	0.2	0.3	*
Misuse of Prescription Psychotherapeutics	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	12.2	13.3	11.5	10.8	9.4	*5.5*
Pain Relievers	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	7.8	9.2	6.5	6.1	4.2	*2.3*
Stimulants	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	5.5	4.6	4.9	3.6	4.9	*2.8*
Tranquilizers or Sedatives	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	3.9	5.5	5.2	4.8	4.6	*2.6*
Tranquilizers	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	3.4	4.8	5.1	4.4	4.1	*2.3*
Sedatives	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	0.8	1.4	0.7	1.0	1.2	*0.3*
Benzodiazepines	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	3.2	4.6	4.8	4.2	3.9	*2.0*
Opioids	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	7.8	9.2	6.6	6.1	4.2	*2.3*
Central Nervous System Stimulants	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	6.0	5.3	5.4	4.5	5.3	*3.4*
Illicit Drugs Other Than Marijuana[1]	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	18.6	17.9	16.0	15.7	15.7	*13.4*
PAST MONTH USE																	
Alcohol	28.4	27.6	26.6	27.4	25.1	24.2	24.0	23.9	22.7	18.9	20.2	17.3	16.5	16.3	16.0	16.9	*16.3*
Binge Alcohol Use[2]	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	9.5	8.7	9.1	8.5	8.9	*6.2*
Heavy Alcohol Use	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	1.7	1.7	1.2	0.6	1.4	*1.2*
Cigarette Use	22.8	20.5	19.2	19.2	17.4	17.2	15.8	15.8	12.8	11.1	9.2	8.0	7.8	6.7	6.1	4.4	*2.7*
Daily Cigarette Use	7.7	5.3	5.2	4.8	3.7	3.6	3.1	4.0	2.7	1.8	1.6	1.8	0.9	0.8	0.7	0.4	*0.1*

* = low precision, -- = not available, da = does not apply; nc = not comparable due to methodological changes, nr = not reported due to measurement issues.
NOTE: Estimates in the 2020 column are italicized to indicate caution should be used when comparing estimates between 2020 and prior years because of methodological changes for 2020. Due to these changes, significance testing between 2020 and prior years was not performed. See the *2020 National Survey on Drug Use and Health: Methodological Summary and Definitions* for details.
NOTE: Some 2006 to 2010 estimates may differ from previously published estimates due to updates (see Chapter 3 of the *2020 National Survey on Drug Use and Health: Methodological Summary and Definitions*).
NOTE: Respondents with unknown past year Major Depressive Episode (MDE) data were excluded.

[1] Illicit Drugs Other Than Marijuana excludes respondents who used only marijuana but includes those who used marijuana in addition to other illicit drugs.
[2] Estimates of binge alcohol use include use by those who were heavy alcohol users.

Definitions: Measures and terms are defined in Appendix A.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2004-2019, and Quarters 1 and 4, 2020.

Table 11.7A Substance Use in Past Year and Past Month: Among People Aged 12 to 17 with Major Depressive Episode with Severe Impairment in Past Year; Numbers in Thousands, 2006-2020

Substance	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
PAST YEAR USE															
Illicit Drugs	nc	nc	nc	nc	nc	nc	nc	nc	nc	774	757	720	885	932	*791*
Marijuana	362	339	384	366	327	375	414	495	510	545	572	547	678	718	*618*
Cocaine	47	54	48	35	35	36	45	17	32	32	30	27	27	29	*27*
Crack	10	17	5	6	7	11	7	2	6	*	4	2	0	10	*
Heroin	9	6	8	6	9	8	11	7	12	2	3	4	3	*	*
Hallucinogens	nc	nc	nc	nc	nc	nc	nc	nc	nc	116	102	122	96	133	*126*
LSD	13	13	23	30	20	23	36	19	45	56	31	58	52	87	*70*
PCP	10	5	16	6	4	7	8	6	11	2	6	11	6	7	*
Ecstasy	nc	nc	nc	nc	nc	nc	nc	nc	nc	43	46	42	42	56	*14*
Inhalants	nc	nc	nc	nc	nc	nc	nc	nc	nc	151	124	119	145	178	*179*
Methamphetamine	nc	nc	nc	nc	nc	nc	nc	nc	nc	10	5	14	6	10	*
Misuse of Prescription Psychotherapeutics	nc	nc	nc	nc	nc	nc	nc	nc	nc	325	349	285	301	301	*188*
Pain Relievers	nc	nc	nc	nc	nc	nc	nc	nc	nc	201	237	170	172	136	*70*
Stimulants	nc	nc	nc	nc	nc	nc	nc	nc	nc	148	130	122	106	157	*100*
Tranquilizers or Sedatives	nc	nc	nc	nc	nc	nc	nc	nc	nc	103	148	131	151	147	*100*
Tranquilizers	nc	nc	nc	nc	nc	nc	nc	nc	nc	89	131	127	136	129	*88*
Sedatives	nc	nc	nc	nc	nc	nc	nc	nc	nc	25	41	19	30	43	*12*
Benzodiazepines	nc	nc	nc	nc	nc	nc	nc	nc	nc	82	125	119	129	124	*73*
Opioids	nc	nc	nc	nc	nc	nc	nc	nc	nc	201	238	172	172	136	*70*
Central Nervous System Stimulants	nc	nc	nc	nc	nc	nc	nc	nc	nc	163	145	133	128	174	*114*
Illicit Drugs Other Than Marijuana[1]	nc	nc	nc	nc	nc	nc	nc	nc	nc	477	450	406	435	482	*386*
PAST MONTH USE															
Alcohol	386	404	385	372	318	331	370	365	421	396	373	398	433	487	*477*
Binge Alcohol Use[2]	nc	nc	nc	nc	nc	nc	nc	nc	nc	228	199	220	238	262	*200*
Heavy Alcohol Use	nc	nc	nc	nc	nc	nc	nc	nc	nc	49	40	29	17	43	*45*
Cigarette Use	290	285	275	276	219	225	217	221	203	213	194	168	177	129	*79*
Daily Cigarette Use	83	75	56	55	46	58	44	32	40	50	19	18	17	12	*6*

* = low precision; -- = not available; da = does not apply; nc = not comparable due to methodological changes; nr = not reported due to measurement issues.
NOTE: Estimates in the 2020 column are italicized to indicate caution should be used when comparing estimates between 2020 and prior years because of methodological changes for 2020. Due to these changes, significance testing between 2020 and prior years was not performed. See the *2020 National Survey on Drug Use and Health: Methodological Summary and Definitions* for details.
NOTE: Some 2006 to 2010 estimates may differ from previously published estimates due to updates (see Chapter 3 of the *2020 National Survey on Drug Use and Health: Methodological Summary and Definitions*).
NOTE: Respondents with unknown past year Major Depressive Episode (MDE) data were excluded.
NOTE: Respondents with unknown impairment data were excluded.

[1] Illicit Drugs Other Than Marijuana excludes respondents who used only marijuana but includes those who used marijuana in addition to other illicit drugs.
[2] Estimates of binge alcohol use include use by those who were heavy alcohol users.

Definitions: Measures and terms are defined in Appendix A.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2006-2019, and Quarters 1 and 4, 2020.

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Table 11.7B Substance Use in Past Year and Past Month: Among People Aged 12 to 17 with Major Depressive Episode with Severe Impairment in Past Year; Percentages, 2006-2020

Substance	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
PAST YEAR USE															
Illicit Drugs	nc	nc	nc	nc	nc	nc	nc	nc	nc	36.3	34.9	31.8	36.5	34.9	*27.1*
Marijuana	26.6	24.7	26.3	26.0	24.3	27.0	26.8	26.5	25.6	25.6	26.4	24.1	28.0	26.9	*21.2*
Cocaine	3.5	4.0	3.3	2.5	2.6	2.6	2.9	0.9	1.6	1.5	1.4	1.2	1.1	1.1	*0.9*
Crack	0.8	1.2	0.4	0.5	0.5	0.8	0.4	0.1	0.3	*	0.2	0.1	0.0	0.4	*
Heroin	0.6	0.5	0.6	0.4	0.6	0.6	0.7	0.4	0.6	0.1	0.1	0.2	0.1	*	*
Hallucinogens	nc	nc	nc	nc	nc	nc	nc	nc	nc	5.5	4.7	5.4	4.0	5.0	*4.3*
LSD	0.9	0.9	1.6	2.1	1.5	1.7	2.3	1.0	2.2	2.6	1.4	2.6	2.1	3.3	*2.4*
PCP	0.8	0.4	1.1	0.4	0.3	0.5	0.5	0.3	0.5	0.1	0.3	0.5	0.2	0.3	*
Ecstasy	nc	nc	nc	nc	nc	nc	nc	nc	nc	2.0	2.1	1.9	1.7	2.1	*0.5*
Inhalants	nc	nc	nc	nc	nc	nc	nc	nc	nc	7.1	5.7	5.2	6.0	6.7	*6.1*
Methamphetamine	nc	nc	nc	nc	nc	nc	nc	nc	nc	0.5	0.2	0.6	0.3	0.4	*
Misuse of Prescription Psychotherapeutics	nc	nc	nc	nc	nc	nc	nc	nc	nc	15.3	16.1	12.6	12.4	11.3	*6.4*
Pain Relievers	nc	nc	nc	nc	nc	nc	nc	nc	nc	9.4	10.9	7.5	7.1	5.1	*2.4*
Stimulants	nc	nc	nc	nc	nc	nc	nc	nc	nc	6.9	6.0	5.4	4.4	5.9	*3.4*
Tranquilizers or Sedatives	nc	nc	nc	nc	nc	nc	nc	nc	nc	4.8	6.8	5.8	6.2	5.5	*3.4*
Tranquilizers	nc	nc	nc	nc	nc	nc	nc	nc	nc	4.2	6.0	5.6	5.6	4.8	*3.0*
Sedatives	nc	nc	nc	nc	nc	nc	nc	nc	nc	1.2	1.9	0.8	1.2	1.6	*0.4*
Benzodiazepines	nc	nc	nc	nc	nc	nc	nc	nc	nc	3.8	5.8	5.2	5.3	4.6	*2.5*
Opioids	nc	nc	nc	nc	nc	nc	nc	nc	nc	9.4	11.0	7.6	7.1	5.1	*2.4*
Central Nervous System Stimulants	nc	nc	nc	nc	nc	nc	nc	nc	nc	7.6	6.7	5.9	5.3	6.5	*3.9*
Illicit Drugs Other Than Marijuana[1]	nc	nc	nc	nc	nc	nc	nc	nc	nc	22.4	20.8	17.9	18.0	18.0	*13.2*
PAST MONTH USE															
Alcohol	28.4	29.5	26.4	26.5	23.6	23.8	24.0	19.5	21.1	18.6	17.2	17.6	17.9	18.2	*16.3*
Binge Alcohol Use[2]	nc	nc	nc	nc	nc	nc	nc	nc	nc	10.7	9.2	9.7	9.8	9.8	*6.9*
Heavy Alcohol Use	nc	nc	nc	nc	nc	nc	nc	nc	nc	2.3	1.8	1.3	0.7	1.6	*1.5*
Cigarette Use	21.3	20.8	18.8	19.7	16.2	16.2	14.1	11.8	10.2	10.0	8.9	7.4	7.3	4.8	*2.7*
Daily Cigarette Use	6.1	5.5	3.8	3.9	3.4	4.2	2.9	1.7	2.0	2.3	0.9	0.8	0.7	0.5	*0.2*

* = low precision, -- = not available, da = does not apply; nc = not comparable due to methodological changes, nr = not reported due to measurement issues.
NOTE: Estimates in the 2020 column are italicized to indicate caution should be used when comparing estimates between 2020 and prior years because of methodological changes for 2020. Due to these changes, significance testing between 2020 and prior years was not performed. See the *2020 National Survey on Drug Use and Health: Methodological Summary and Definitions* for details.
NOTE: Some 2006 to 2010 estimates may differ from previously published estimates due to updates (see Chapter 3 of the *2020 National Survey on Drug Use and Health: Methodological Summary and Definitions*).
NOTE: Respondents with unknown past year Major Depressive Episode (MDE) data were excluded.
NOTE: Respondents with unknown impairment data were excluded.

[1] Illicit Drugs Other Than Marijuana excludes respondents who used only marijuana but includes those who used marijuana in addition to other illicit drugs.
[2] Estimates of binge alcohol use include use by those who were heavy alcohol users.

Definitions: Measures and terms are defined in Appendix A.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2006-2019, and Quarters 1 and 4, 2020.

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Table 11.8A Substance Use in Past Year and Past Month: Among People Aged 12 to 17 with No Major Depressive Episode in Past Year; Numbers in Thousands, 2004-2020

Substance	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
PAST YEAR USE																	
Illicit Drugs	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	3,251	2,823	3,010	2,888	2,926	*2,158*
Marijuana	2,998	2,763	2,803	2,629	2,693	2,810	2,836	2,962	2,746	2,561	2,479	2,366	2,136	2,283	2,164	2,256	*1,582*
Cocaine	335	335	337	302	238	196	178	165	123	93	115	115	91	*87*	66	67	*46*
Crack	44	37	57	45	22	18	9	18	12	7	5	5	4	14	1	2	*2*
Heroin	37	23	26	15	27	25	18	36	20	20	13	14	9	7	5	*	*
Hallucinogens	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	371	308	346	254	279	*212*
LSD	117	108	86	108	150	97	103	113	106	108	163	177	157	173	136	171	*124*
PCP	47	64	47	48	40	35	26	26	36	20	22	29	12	10	7	14	*
Ecstasy	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	151	111	121	80	78	*50*
Inhalants	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	457	378	418	460	476	*365*
Methamphetamine	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	22	23	31	32	28	*11*
Misuse of Prescription Psychotherapeutics	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	1,044	851	824	767	643	*427*
Pain Relievers	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	700	556	526	444	358	*284*
Stimulants	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	305	275	280	231	230	*153*
Tranquilizers or Sedatives	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	315	285	313	275	239	*191*
Tranquilizers	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	277	260	282	253	214	*85*
Sedatives	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	73	50	50	29	34	*17*
Benzodiazepines	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	260	250	280	243	212	*71*
Opioids	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	710	563	526	448	358	*284*
Central Nervous System Stimulants	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	397	340	350	292	281	*186*
Illicit Drugs Other Than Marijuana[1]	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	1,610	1,335	1,373	1,284	1,181	*891*
PAST MONTH USE																	
Alcohol	3,741	3,515	3,635	3,413	3,088	3,114	2,793	2,759	2,660	2,316	2,219	1,823	1,726	1,862	1,618	1,658	*1,358*
Binge Alcohol Use[2]	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	1,127	901	990	843	837	*765*
Heavy Alcohol Use	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	165	132	129	105	146	*89*
Cigarette Use	2,420	2,221	2,214	2,047	1,858	1,825	1,659	1,557	1,294	1,042	900	755	574	538	427	368	*228*
Daily Cigarette Use	628	568	583	527	417	433	388	349	285	212	229	141	94	68	73	55	*19*

* = low precision; -- = not available; da = does not apply; nc = not comparable due to methodological changes; nr = not reported due to measurement issues.
NOTE: Estimates in the 2020 column are italicized to indicate caution should be used when comparing estimates between 2020 and prior years because of methodological changes for 2020. Due to these changes, significance testing between 2020 and prior years was not performed. See the *2020 National Survey on Drug Use and Health: Methodological Summary and Definitions* for details.
NOTE: Some 2006 to 2010 estimates may differ from previously published estimates due to updates (see Chapter 3 of the *2020 National Survey on Drug Use and Health: Methodological Summary and Definitions*).
NOTE: Respondents with unknown past year Major Depressive Episode (MDE) data were excluded.

[1] Illicit Drugs Other Than Marijuana excludes respondents who used only marijuana but includes those who used marijuana in addition to other illicit drugs.
[2] Estimates of binge alcohol use include use by those who were heavy alcohol users.

Definitions: Measures and terms are defined in Appendix A.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2004-2019, and Quarters 1 and 4, 2020.

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Table 11.8B Substance Use in Past Year and Past Month: Among People Aged 12 to 17 with No Major Depressive Episode in Past Year; Percentages, 2004-2020

Substance	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
PAST YEAR USE																	
Illicit Drugs	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	15.3	13.4	14.3	14.0	14.4	*10.7*
Marijuana	13.3	12.1	12.2	11.6	12.0	12.7	12.9	13.2	12.4	11.8	11.6	11.1	10.1	10.9	10.5	11.1	*7.9*
Cocaine	1.5	1.5	1.5	1.3	1.1	0.9	0.8	0.7	0.6	0.4	0.5	0.5	0.4	0.4	0.3	0.3	*0.2*
Crack	0.2	0.2	0.2	0.2	0.1	0.1	0.0	0.1	0.1	0.0	0.0	0.0	0.0	0.1	0.0	0.0	*0.0*
Heroin	0.2	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.1	0.1	0.1	0.1	0.0	0.0	0.0	*	*
Hallucinogens	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	1.7	1.5	1.6	1.2	1.4	*1.1*
LSD	0.5	0.5	0.4	0.5	0.7	0.4	0.5	0.5	0.5	0.5	0.8	0.8	0.7	0.8	0.7	0.8	*0.6*
PCP	0.2	0.3	0.2	0.2	0.2	0.2	0.1	0.1	0.2	0.1	0.1	0.1	0.1	0.0	0.0	0.1	*
Ecstasy	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	0.7	0.5	0.6	0.4	0.4	*0.2*
Inhalants	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	2.2	1.8	2.0	2.2	2.3	*1.8*
Methamphetamine	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	0.1	0.1	0.1	0.2	0.1	*0.1*
Misuse of Prescription Psychotherapeutics	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	4.9	4.0	3.9	3.7	3.2	*2.1*
Pain Relievers	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	3.3	2.6	2.5	2.2	1.8	*1.4*
Stimulants	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	1.4	1.3	1.3	1.1	1.1	*0.8*
Tranquilizers or Sedatives	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	1.5	1.3	1.5	1.3	1.2	*0.5*
Tranquilizers	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	1.3	1.2	1.3	1.2	1.1	*0.4*
Sedatives	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	0.3	0.2	0.2	0.1	0.2	*0.1*
Benzodiazepines	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	1.2	1.2	1.3	1.2	1.0	*0.4*
Opioids	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	3.3	2.7	2.5	2.2	1.8	*1.4*
Central Nervous System Stimulants	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	1.9	1.6	1.7	1.4	1.4	*0.9*
Illicit Drugs Other Than Marijuana[1]	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	7.6	6.3	6.5	6.2	5.8	*4.4*
PAST MONTH USE																	
Alcohol	16.5	15.4	15.8	15.0	13.8	14.1	12.8	12.3	12.0	10.7	10.3	8.6	8.2	8.9	7.8	8.2	*6.7*
Binge Alcohol Use[2]	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	5.3	4.3	4.7	4.1	4.1	*3.8*
Heavy Alcohol Use	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	nc	0.8	0.6	0.6	0.5	0.7	*0.4*
Cigarette Use	10.7	9.8	9.7	9.0	8.3	8.2	7.6	7.0	5.8	4.8	4.2	3.6	2.7	2.6	2.1	1.8	*1.1*
Daily Cigarette Use	2.8	2.5	2.5	2.3	1.9	2.0	1.8	1.6	1.3	1.0	1.1	0.7	0.4	0.3	0.4	0.3	*0.1*

* = low precision; -- = not available; da = does not apply; nc = not comparable due to methodological changes; nr = not reported due to measurement issues.
NOTE: Estimates in the 2020 column are italicized to indicate caution should be used when comparing estimates between 2020 and prior years because of methodological changes for 2020. Due to these changes, significance testing between 2020 and prior years was not performed. See the *2020 National Survey on Drug Use and Health: Methodological Summary and Definitions* for details.
NOTE: Some 2006 to 2010 estimates may differ from previously published estimates due to updates (see Chapter 3 of the *2020 National Survey on Drug Use and Health: Methodological Summary and Definitions*).
NOTE: Respondents with unknown past year Major Depressive Episode (MDE) data were excluded.

[1] Illicit Drugs Other Than Marijuana excludes respondents who used only marijuana but includes those who used marijuana in addition to other illicit drugs.
[2] Estimates of binge alcohol use include use by those who were heavy alcohol users.

Definitions: Measures and terms are defined in Appendix A.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2004-2019, and Quarters 1 and 4, 2020.

Table 11.9A Type of Treatment Received in Past Year for Depression: Among People Aged 12 to 17 with Major Depressive Episode (MDE) in Past Year and among People Aged 12 to 17 with MDE with Severe Impairment in Past Year; Numbers in Thousands, 2004-2020

MDE/Type of Treatment	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
MDE																	
Saw or Talked to a Health Professional OR Used Prescription Medication	856	778	700	739	731	638	682	724	791	944	1,076	1,139	1,223	1,286	1,371	1,577	*1,685*
Saw or Talked to a Health Professional BUT Did Not Use Prescription Medication	425	404	407	372	406	358	370	397	431	522	543	596	571	625	749	796	*928*
Used Prescription Medication BUT Did Not See or Talk to a Health Professional	76	58	47	53	60	46	58	52	52	94	75	87	59	76	77	127	*53*
Saw or Talked to a Health Professional AND Used Prescription Medication	342	308	241	307	259	231	252	272	302	316	447	447	576	570	533	645	*691*
MDE with Severe Impairment																	
Saw or Talked to a Health Professional OR Used Prescription Medication	--	--	575	574	598	515	528	570	618	808	851	924	986	1,044	1,094	1,287	*1,344*
Saw or Talked to a Health Professional BUT Did Not Use Prescription Medication	--	--	314	281	313	283	280	303	309	421	423	468	413	477	575	622	*724*
Used Prescription Medication BUT Did Not See or Talk to a Health Professional	--	--	37	39	49	37	34	33	43	86	63	66	48	54	55	99	*38*
Saw or Talked to a Health Professional AND Used Prescription Medication	--	--	220	249	232	191	212	232	260	287	360	386	513	505	455	560	*570*

* = low precision; -- = not available; da = does not apply; nc = not comparable due to methodological changes; nr = not reported due to measurement issues.
NOTE: Estimates in the 2020 column are italicized to indicate caution should be used when comparing estimates between 2020 and prior years because of methodological changes for 2020. Due to these changes, significance testing between 2020 and prior years was not performed. See the *2020 National Survey on Drug Use and Health: Methodological Summary and Definitions* for details.
NOTE: Some 2006 to 2010 estimates may differ from previously published estimates due to updates (see Chapter 3 of the *2020 National Survey on Drug Use and Health: Methodological Summary and Definitions*).
NOTE: Respondents with unknown past year treatment for depression data were excluded.
NOTE: Respondents with unknown past year Major Depressive Episode (MDE) data were excluded.

Definitions: Measures and terms are defined in Appendix A.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2004-2019, and Quarters 1 and 4, 2020.

Table 11.9B Type of Treatment Received in Past Year for Depression: Among People Aged 12 to 17 with Major Depressive Episode (MDE) in Past Year and among People Aged 12 to 17 with MDE with Severe Impairment in Past Year; Percentages, 2004-2020

MDE/Type of Treatment	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
MDE																	
Saw or Talked to a Health Professional OR Used Prescription Medication	38.7	35.9	35.9	37.0	36.3	33.0	35.8	36.3	36.0	36.9	39.6	37.9	40.2	40.3	40.0	42.2	*41.2*
Saw or Talked to a Health Professional BUT Did Not Use Prescription Medication	19.3	18.6	20.9	18.6	20.2	18.5	19.4	19.9	19.6	20.4	20.0	19.8	18.8	19.6	21.8	21.3	*22.6*
Used Prescription Medication BUT Did Not See or Talk to a Health Professional	3.4	2.7	2.4	2.7	3.0	2.4	3.0	2.6	2.4	3.7	2.8	2.9	1.9	2.4	2.2	3.4	*1.3*
Saw or Talked to a Health Professional AND Used Prescription Medication	15.5	14.1	12.3	15.3	12.8	11.9	13.2	13.6	13.7	12.3	16.4	14.8	18.9	17.9	15.4	17.1	*16.8*
MDE with Severe Impairment																	
Saw or Talked to a Health Professional OR Used Prescription Medication	--	--	42.9	42.1	41.1	37.0	39.3	41.3	40.2	43.8	43.2	43.7	46.1	46.2	45.5	48.7	*46.6*
Saw or Talked to a Health Professional BUT Did Not Use Prescription Medication	--	--	23.4	20.6	21.5	20.3	20.8	21.9	20.1	22.9	21.5	22.1	19.3	21.1	24.0	23.5	*24.9*
Used Prescription Medication BUT Did Not See or Talk to a Health Professional	--	--	2.7	2.9	3.3	2.7	2.5	2.4	2.8	4.7	3.2	3.1	2.3	2.4	2.3	3.7	*1.3*
Saw or Talked to a Health Professional AND Used Prescription Medication	--	--	16.4	18.3	15.9	13.7	15.7	16.7	16.9	15.6	18.2	18.2	24.0	22.4	18.9	21.0	*19.6*

* = low precision; -- = not available; da = does not apply; nc = not comparable due to methodological changes; nr = not reported due to measurement issues.
NOTE: Estimates in the 2020 column are italicized to indicate caution should be used when comparing estimates between 2020 and prior years because of methodological changes for 2020. Due to these changes, significance testing between 2020 and prior years was not performed. See the *2020 National Survey on Drug Use and Health: Methodological Summary and Definitions* for details.
NOTE: Some 2006 to 2010 estimates may differ from previously published estimates due to updates (see Chapter 3 of the *2020 National Survey on Drug Use and Health: Methodological Summary and Definitions*).
NOTE: Respondents with unknown past year treatment for depression data were excluded.
NOTE: Respondents with unknown past year Major Depressive Episode (MDE) data were excluded.

Definitions: Measures and terms are defined in Appendix A.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2004-2019, and Quarters 1 and 4, 2020.

CHILDRENS HOSPITAL ASSOCIATION STATEMENT FOR THE RECORD

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Children's Hospital Association Statement for Record

Senate Committee on Health, Education, Labor and Pensions, Subcommittee on Children and Families, "Caring for Our Kids: Supporting Mental Health in the Transition from High School to College"

November 30, 2022

On behalf of the nation's children's hospitals and the children and families we serve, thank you for holding this hearing on supporting the mental health of America's adolescents and youth, particularly during the challenging transition period into young adulthood. We appreciate the Senate HELP Committee's continued attention to the crisis in child and adolescent mental health throughout this year. We need urgent tailored action and investments for children to meaningfully address the national children's mental health emergency. Our nation's children cannot wait.

Children's Hospital Association represents more than 220 children's hospitals nationwide, dedicated to advancing the health and well-being of our nation's children through innovation in the quality, cost, and delivery of care. The mental health challenges facing our children continue to grow and our hospitals are seeing it firsthand in their emergency departments (EDs). Visits for youth suicide attempts have increased dramatically, eating disorder visits have doubled and we are seeing an increase in suicide rates for children and teens, with steeper increases among Black boys and girls under age 12. As essential providers dedicated to providing the highest quality pediatric care, addressing the children's mental health crisis is our top priority.

The periods of adolescence and early adulthood are critical for the emergence of mental health conditions, as 50% of all mental illness begins by age 14, and 75% by age 24. Yet, promoting and protecting the mental health of teens and young adults begins with a strong foundation for mental health in childhood. Improving outcomes for youth requires ensuring that children have opportunities to develop and strengthen critical social, emotional and coping skills, as well as facilitating early identification and access to developmentally appropriate treatment, including for children who are not yet diagnosed.

We encourage the HELP Committee, in partnership with your colleagues on the Senate Finance Committee and in the House of Representatives, to take steps now to safeguard children's mental health from early childhood and into young adulthood. Children's hospitals urge Congress to:

- Support the pediatric mental health workforce
- Bolster community-based systems of pediatric mental health care
- Provide dedicated resources to enhance pediatric mental health infrastructure
- Strengthen programs targeted to support mental health among teens and young adults

Children's hospitals strongly support S. 4472, the Health Capacity for Pediatric Behavioral Health Act sponsored by the Subcommittee Chair Bob Casey, D-Pa., and Ranking Member Bill Cassidy, R-La. This legislation would address these three critical facets of the children's mental health crisis, described in detail below, with dedicated grant funding through the Health Resources and Services Administration.

Support the pediatric mental health workforce

A robust, diverse, pediatric behavioral health workforce is essential to meet children's mental, emotional and behavioral health needs with developmentally appropriate treatment delivered across the continuum care. Workforce shortages persists across pediatric behavioral health professions, which delays and too often prevents children from receiving mental health care when they need it, leaving children's conditions to worsen without intervention. Current programs not tailored and dedicated to the pediatric workforce are not meeting children's needs. We need tailored federal investments, specifically for pediatrics, to support the recruitment and retention of a diverse workforce across pediatric behavioral health professional fields, including both clinical and non-clinical roles. Additionally, growing the workforce will take time, so we must also better equip the existing workforce to meet children's mental health needs, with enhanced training and support for care coordination and integration.

Bolster community-based systems of pediatric mental health care

Children's hospitals are continuing to see higher rates of youth presenting in mental health crisis at emergency departments, which is not the ideal place for a young person in distress and too often results in them boarding while they wait for space to become available in an appropriate treatment setting. We know the best way to prevent this is to identify children and adolescents' needs earlier and connect them to mental health care within their communities. However, many communities have a long way to go toward establishing robust, well-coordinated systems of pediatric behavioral health care, and state and federal resources are often utilized disproportionately for adult services. We encourage Congress to direct funds to strengthen pediatric community-based mental health services, allowing communities to develop new or improve existing programs and policies to fill service gaps and better meet the mental and behavioral health needs of children, teens, and young adults locally.

Provide dedicated resources to enhance pediatric mental health infrastructure

In order to expand and sustain a full continuum of mental and behavioral health services for children and teens, which provides adequate support and connection to youth as they transition to adulthood, investments are needed to strengthen critical pediatric mental health infrastructure. There is insufficient pediatric capacity to deliver higher and intermediate levels of care, such as inpatient psychiatric treatment, for those young people who need it, contributing to a crisis in mental health boarding. We specifically urge Congress to provide resources to support efforts to scale up inpatient care capacity, including costs associated with the conversion of general beds to accommodate mental health patients. There is also a vital need to increase access to alternatives to inpatient and emergency department care including stepdown, partial hospitalization, intensive outpatient services and day programs. Children's hospitals recommend that lawmakers take additional actions this year to strengthen pediatric behavioral health infrastructure and improve access to care, both immediately and long-term.

Strengthen programs targeted to support mental health among teens and young adults

Effectively promoting mental health among teens and youth transitioning into adulthood necessitates meeting them where they are, making schools and colleges critical connection points for screening and support. Many mental health conditions in youth can be managed, especially if identified early, through community-based outpatient treatment. Children's hospitals have long supported school-based mental health and suicide prevention programs, especially in partnerships with children's hospitals and other pediatric mental health providers to facilitate referrals to appropriate care. We have supported S. 1841/H.R. 721, the Mental Health Services for Students Act, which passed the House with bipartisan support earlier this year and would expand comprehensive school mental health

programs and training for school professionals through the Substance Abuse and Mental Health Services Administration's Project AWARE program. We also support S. 4271/H.R. 7255, the Garret Lee Smith Memorial Reauthorization Act, which will increase funding for effective suicide prevention programs with teens, on college campuses and within tribal communities.

Thank you again for your commitment to improving mental and behavioral health care delivery systems for children, teens, and young adults. Children's hospitals urge you to take additional steps before the end of this year to help children and young people struggling with mental health conditions to get the care they need.

AAFP STATEMENT FOR THE RECORD

AAFP Statement for the Record

November 30, 2022 HELP Subcommittee on Children and Families Hearing: "Caring for Our Kids: Supporting Mental Health in the Transition from High School to College"

Background

College students are often assuming responsibility for their health care for the first time. Although they are generally healthy, many have special health care needs such as asthma, diabetes mellitus, mental health concerns, and learning disorders. Depression, anxiety, sleep problems, and posttraumatic stress and eating disorders are common in this population and can affect school performance. As noted in AAFP policy, mental health concerns, such as non-suicidal self-injury and serious suicidal ideation, have risen among college students over the past several years.

Understanding and managing the needs of this dynamic population involve addressing the unique psychosocial stressors related to this life transition that manifest before and while attending college. Poor transitions of youth to adult care can result in declines in treatment adherence, increased emergency department use, and increased hospitalizations.

As detailed in our testimony to the Committee earlier this year, family physicians provide comprehensive mental health services and are a major source for mental health care in the US. Nearly 40% of all visits for depression, anxiety, or cases defined as "any mental illness" were with primary care physicians, and primary care physicians are more likely to be the source of physical and mental health care for patients with lower socioeconomic status and for those with co-morbidities. **Family physicians are uniquely equipped to support the transition of a youth to an adult model of health care for college students.** Family physicians are the only primary care physicians trained to care for children, adolescents, *and* adults, which enables them to care for patients across the lifespan. They have an existing relationship and established trust with the patient, as well as an understanding of a patient's medical history, including mental and behavioral health conditions, which allows them to help facilitate appropriate and continuous care.

Last year, the AAFP joined the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, and the Children's Hospital Association in declaring a National State of Emergency in Children's Mental Health. We also joined a letter to Congressional leadership last month about the need for further legislation to address this issue.

As the Committee weighs the mental and behavioral health needs of college students, the AAFP strongly urges recognition of the important role primary care physicians play in the provision of mental health care services for college students. **We urge the Committee to support policies that strengthen and build upon existing patient-physician relationships.**

Telehealth Services

Telehealth allows patients to maintain access to their family physician and ensures continuity of care for students who are away at college. It can enhance the patient-physician relationship, increase access to care, improve health outcomes by enabling timely care interventions, and decrease costs when utilized as a component of, and coordinated with, continuous care. Mental health services, in particular, are well-suited to be delivered virtually.

A nationwide survey found that patients were most willing to see their usual physician via telemedicine and most felt it was very important that the telehealth provider have access to their complete medical record. Protecting and promoting continuity of care is essential to realizing the care quality improvements and cost reductions with the integration of telehealth. **Any permanent expansion of telehealth benefits should be structured in a way that not only increases access to care but also promotes high-quality, comprehensive, continuous care,** as outlined in our joint principles for telehealth policy. We note that tele-mental health services provided by virtual-only companies could, in some cases, be an appropriate substitute for traditional in-person care and significantly increase access to needed behavioral health services; however, such care should always include communication and coordination with the patient's usual source of primary care.

College students may experience challenges to accessing continuous mental health and other essential services. For example, many colleges only offer a few free counseling visits. Telehealth visits with a patient's usual source of care could improve timely, ongoing access to services. Unfortunately, accessing telehealth care across state lines remains a challenge for college students especially, as many pursue educational opportunities in a different state than where their primary care physician is located. Additionally, family physicians often cite state licensure requirements as a barrier to providing virtual care to their patients when they are travelling or temporarily residing in another state. Most states require physicians to obtain a license to practice medicine in the state where the patient is located, annually register with the state's board, or obtain a licensure by endorsement/telemedicine waiver. These processes are administratively burdensome, costly, and time intensive for physicians. However, **the AAFP has long supported licensure at the state level in order to ensure patient safety and necessary oversight.**

Congress could consider legislation to **allow physicians to provide telehealth services to out of state enrolled college and graduate-level students with an established physician-patient relationship to avoid emergency room and inpatient psychiatric hospitalizations.** Patients with an established relationship, who are traveling, should be allowed to be treated by their primary care physician, so long as the physician is licensed in the state in which the patient receives their usual care. In this case, as long as the student has an established relationship with their primary care physician in the student's home state, they should be able to see their primary care physician while in school, out of state. Such legislation could specify that the student's home state retains the authority to conduct oversight and

enforcement activities related to the care provided to college and graduate students located in other states. This could improve access to care for college students while also guarding against fraud or patient safety concerns.

The Interstate Medical Licensure Compact (IMLC) offers an expedited pathway for physicians to apply for and receive licenses from participating states. We encourage states to engage in reciprocity compacts for physician licensing like the IMLC, especially to permit the use of telehealth. While the IMLC helps to expedite the licensure process, family physicians report that it is still burdensome and costly. Physicians must apply to participate in the IMLC, provide additional information to states to obtain licensure, and regularly renew each individual state license. According the IMLC website, physicians are required to pay a $700.00 application fee to participate in the IMLC in addition to state licensing and renewal fees for each state they wish to be licensed in. **The AAFP supports efforts to improve and streamline the IMLC to support family physicians providing virtual care to *all* their established patients across state lines. We urge Congress to consider federal policy options to:**

- Subsidize the cost of the IMLC application fee and state licensing fees;
- Improve the sharing of licensure and other relevant information between states in order to reduce the burden of application and renewal on physicians and reduce licensing wait times;
- Encourage all states to participate in the IMLC and create streamlined licensure or waiver processes for physicians in other states caring for patients with whom there is an established patient-physician relationship.

[Whereupon, at 11:34 a.m., the hearing was adjourned.]

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