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AMERICANS IN NEED:

RESPONDING TO THE NATIONAL MENTAL HEALTH CRISIS

THURSDAY, FEBRUARY 17, 2022

House of Representatives,

Subcommittee on Oversight and Investigations,

Committee on Energy and Commerce,

Washington, D.C.

The subcommittee met, pursuant to call, at 11:34 a.m., in the John D. Dingell Room, 2123 of the Rayburn House Office Building, Hon. Diana DeGette, [chairwoman of the subcommittee] presiding.

Present: Representatives DeGette, Kuster, Schakowsky, Tonko, Ruiz, Peters, Schrier, Trahan, O'Halleran, Pallone (ex officio); Griffith, Burgess, McKinley, Long, Palmer, Dunn, Joyce, and Rodgers (ex officio).

Also present: Representatives Armstrong, Blunt Rochester, Cardenas, and Latta.

Staff Present: Jesseca Boyer, Professional Staff

Member; Austin Flack, Junior Professional Staff Member; Waverly Gordon, Deputy Staff Director and General Counsel; Tiffany Guarascio, Staff Director; Perry Hamilton, Clerk; Fabrizio Herrera, Staff Assistant; Zach Kahan, Deputy Director Outreach and Member Service; Mackenzie Kuhl, Press Assistant; Will McAuliffe, Counsel; Kaitlyn Peel, Digital Director; Chloe Rodriguez, Clerk; Andrew Souvall, Director of Communications, Outreach, and Member Services; Kate Arey, Minority Content Manager and Digital Assistant; Sarah Burke, Minority Deputy Staff Director; Marissa Gervasi, Minority Counsel O&I; Brittany Havens, Minority Professional Staff Member, O&I; Nate Hodson, Minority Staff Director; Peter Kielty, Minority General Counsel; Emily King, Minority Member Services Director; Bijan Koohmaraie, Minority Chief Counsel, O&I Chief Counsel; Clare Paoletta, Minority Policy Analyst, Health; Olivia Shields, Minority Communications Director; Alan Slobodin, Minority Chief Investigative Counsel, O&I; and Michael Taggart, Minority Policy Director.

*Ms. DeGette. The Subcommittee on Oversight and Investigations hearing will now come to order.

Today the Subcommittee on Oversight and Investigations is holding a hearing entitled, "Americans in Need: Responding to the National Mental Health Crisis.'' Today's hearing will examine the growing mental health crisis in the United States.

During the COVID-19 public health emergency, members can participate in today's hearing either in person or remotely, via online video conferencing. Members, staff, and members of the press present in the hearing room must wear a mask, in accordance with the updated guidance issued by the Attending Physician.

And for members participating remotely, your microphones will be set on mute for the purpose of eliminating inadvertent background noise. Members participating remotely will need to unmute your microphone each time you speak. Please note, once you unmute your microphone, anything that is said in Webex will be heard over the loudspeakers in the committee room, and subject to be heard by the live stream and C-SPAN. All of us have had that unfortunate experience during the pandemic, so let's be vigilant.

Because members are participating from different locations at today's hearing, all recognition of members, such as for questions, will be in order of subcommittee

seniority.

And I know we have many of our members of the full committee who are waiving on today. We welcome you, and your questions will be in order of full committee seniority after the subcommittee members have been recognized.

And if any time I am unable to chair the hearing, the vice chair of the subcommittee, Mr. Peters, will serve as chair until I can return.

Documents for the record can be sent to Austin Flack at the email address we have provided to staff. All documents will be entered into the record at the conclusion of the hearing.

And the chair now recognizes herself for five minutes for purposes of an opening statement.

The nation has faced a growing mental health challenge for years, as we all know, which has only been magnified by the COVID-19 pandemic. Today's hearing is an opportunity for the subcommittee to continue its bipartisan and long history of examining ways to support Americans' mental health.

We have prioritized this issue in the Oversight Subcommittee for many years, under the leadership of both parties. But now it is more critical than ever that we better understand the drivers behind the mental health crisis facing Americans, and explore what must -- more must be done to further the shared goal of supporting their mental health

and well-being.

One in five adults and six youth will experience a mental health crisis each year. Over the course of the pandemic, in fact, an estimated 125 million Americans struggled with mental health issues like anxiety, depression, and other mental health illnesses. These statistics are, frankly, alarming.

It is clear the COVID-19 pandemic has increased the mental health challenges that we face as a country, and those whose lives have been more disrupted by COVID-19 have suffered more severe mental health consequences.

Just as communities of color have been disproportionately impacted by the virus itself, so too have people of color experienced disproportionate rates of mental health challenges. People with disabilities are now experiencing mental distress five times as often as adults without disabilities. And essential workers on the front lines of the pandemic, including the health care workers like those in my home state of Colorado and around the country, are experiencing burnout and reporting their own increased mental health struggles.

This committee and Congress have taken steps to address the surging mental health needs through COVID-19 relief packages and other critical legislation. But, as we well know on this subcommittee, our work is long from finished.

The situation is particularly urgent because the nation's children are not immune to this crisis. As this subcommittee heard from experts last fall in our hearing exploring the impacts of COVID-19 on youth, children are facing an increasing number of stressors in their lives. And this is also made evidenced by the staggering increase of behavioral health visits to emergency departments by children last year. For example, in 2021 at Children's Hospital here, in Colorado, 70 percent more children came to the ER because of a mental health crisis than in the very same period in 2019.

Now, there is a reason -- a number of reasons -- behind this increase in crisis in children and adults, but we know that online content plays a part. We are spending a lot more time online, for good or for bad, and the potential harms of social media, online misinformation, and cyber bullying are real threats.

But also, there are real needs to connect with resources and peers in moments of need. And this too has been evident over the past few years, as physical distancing has been necessary to protect our physical health. Virtual connection proved critical to protecting our emotional well-being, and we also addressed this in many of our relief efforts.

More must be done to understand the potential benefits, but while at the same time mitigating the harms because

virtual tools also proved essential for mental health counseling. Telehealth counseling and health care enable millions of people to connect with providers at a time when need for these services surged. But we know that access to mental health services remains an ongoing hurdle for too many people, particularly children and people in vulnerable communities.

Stigma, high cost, and limited coverage and other systemic inquiries all pose barriers to care.

Also, worker shortages across the mental health field have been exacerbated by demands on those frontline workers. The psychiatric workforce alone within the mental health professional workforce in the U.S., for example, is only 28 percent of the total population need for psychiatrists.

Hospital emergency departments have experienced dramatic spikes in the hospitalization of pediatric patients for mental health reasons, and too often the lack of early screening and integrated health care for kids and adults only increases the crisis. So that is why resources like the National Suicide Prevention Lifeline are so crucial.

While efforts are underway to prepare for the expected increase of calls and texts with the new 988 three-digit dialing code this summer, anybody struggling today can get help by calling 1-800-273-8255. And I know Mr. Cardenas is waiving onto this committee today to talk about this very

issue, and I look forward to that.

I look forward to hearing about other resources that people can have from the witnesses today, as well as strategies to de-stigmatize discussions on mental health and emotional well-being. If we can better understand the drivers behind the growing mental health epidemic across the country, we can take more effective action to improve Americans' overall health and their lives. And we have got to ensure that everybody has access to this.

[The prepared statement of Ms. DeGette follows:]

**********COMMITTEE INSERT**********

*Ms. DeGette. With that, I am very pleased now to yield five minutes to the ranking member, Mr. Griffith.

*Mr. Griffith. Thank you very much, Chair DeGette, and I appreciate you holding this hearing.

This hearing comes at a critical time. Dealing with the pandemic these last two years has taken a significant toll on many people, resulting in troubling increases in levels of mental health issues in the United States. Data from the Centers for Disease Control and Prevention, CDC, and the National Health Interview Surveys show American adults are reporting significantly elevated levels of adverse mental health conditions, such as anxiety and depression, as well as increased substance use and suicidal ideations. A growing number of scientific studies also indicate concerning trends with respect to our nation's mental health, and tend to show that different populations are affected in different ways.

The COVID-19 pandemic has had a major impact on our nation's mental health and well-being, exacerbating and creating increased levels of anxiety and depression for many Americans. And it is no wonder, as we have faced significant hardships during the pandemic: individual experiences of severe or long-lasting COVID-19 cases; loss of loved ones to the virus; high levels of on-the-job stress and trauma for frontline and essential workers; job loss and economic uncertainty for families; and school closures inhibiting both

academic and social development.

Just last week, the U.S. Surgeon General testified the pandemic has had a devastating impact on the mental health of America's young people. School closures and lockdowns, in particular, have been associated with adverse mental health symptoms. It is important for us to remember that school is not just where our children are taught reading and math and science. It is also where our kids socialize, where many find reliable access to meals, where there are opportunities to interact with counselors and trusted adults.

Americans deserve a comprehensive approach to public health that balances COVID-19 mitigation efforts with other considerations. While it may have been wise to implement certain policies at the outset of COVID-19, many of them have been unnecessarily prolonged. Of course, we want to prevent as many deaths from COVID-19 as possible, but a death by suicide is just as devastating as death from COVID-19 itself. We must consider mental health as we evaluate the impact of current policies, and as we develop policies for the future.

In addition to concerns about the impact of the pandemic on youth mental health, the Surgeon General noted problems with access to care. During the COVID-19 pandemic, demand for mental health services increased substantially, and providers have reported difficulty meeting demand. This is an area where we need to work to address -- to ensure that

individuals have sufficient access to any care they may need.

The pandemic and the government's response to COVID-19 has also been a factor in the staggering increase in overdose deaths. Provisional data from the CDC indicates there were an estimated 103,306 overdose deaths in the U.S. during the 12-month period ending April 2021, an increase of nearly 30 percent from the number of deaths reported in the same period the year before.

We know that mental health and substance use disorders are -- often overlap and are co-occurring. Multiple national surveys have found that about half of those who experience mental illness during their lives will also experience a substance use disorder, and vice versa. Thus, it is critical that, in addition to addressing our nation's mental health, we also examine how to best address the increase of substance use disorders and overdose deaths throughout the United States.

The mental health of our nation has been and will continue to be a top priority of this committee. I look forward to today's discussion and to learning more about how to best address the mental health needs of our nation.

I thank the witnesses for being here today, and being a part of this important conversation.

[The prepared statement of Mr. Griffith follows:]

**********COMMITTEE INSERT**********

*Mr. Griffith. And I yield back, Madam Chair.

*Ms. DeGette. Thank you, Mr. Griffith. The chair now recognizes the chairman of the full committee, Mr. Pallone, for his opening statement, five minutes.

*The Chairman. Thank you, Chairwoman DeGette.

Today the committee continues its critical work on how to best support the mental health and well-being of Americans who have faced ongoing mental health challenges. And of course, these have been exacerbated by the COVID-19 pandemic.

While the need for mental health care is greater than ever, there are still too many obstacles for people to access that care. One in five American adults reported that the pandemic had a significant negative impact on their mental health, yet only forty-five percent of adults with mental illness were able to access the mental health treatment they needed in 2020. And children, particularly children of color, are experiencing increasing rates of mental health conditions. In fact, in 2020, mental health emergency department visits rose by 24 percent or more for children between the ages of 5 and 17.

Americans seeking mental health care face a range of barriers, including stigma and discrimination, workforce shortages, and concerns over the cost and coverage of care. And this committee has a long history of addressing these barriers to care, including ensuring parity for mental health

and substance use benefits to other health benefits. We played a central role in both the passage of the Mental Health Parity and Addiction Equity Act and in the expansion of parity to individual market plans in the Affordable Care Act.

Then, last year, we led efforts to equip the Departments of Labor, Treasury, and Health and Human Services with new enforcement tools to strengthen and enforce parity in the Consolidated Appropriations Act of 2021. This law requires insurance companies to submit analysis of their coverage of mental health and substance use disorder benefits to the three Departments, so that the Departments can then provide an annual report to Congress on their findings.

Unfortunately, their first report, which was just released, found that insurance companies are failing to deliver parity for mental health and substance use disorder benefits, and are falling short of their obligations under the law. It is unacceptable that insurance companies are flouting the law. Clearly, more must be done to strengthen the protections of mental health parity laws, and we must ensure that Americans' health coverage includes robust coverage and access to treatment for mental health and substance use disorder benefits.

Now, access to mental health has never been more crucial. Suicide remains the second leading cause of death

amongst Americans aged 10 to 34, and we know that mental health challenges are often compounded. For instance, roughly half of Americans experiencing mental illness will also experience a co-occurring substance use disorder.

Thankfully, we took swift action to help meet the growing mental health needs of Americans during the COVID-19 pandemic. Through the fiscal year 2021 funding bill, the CARES Act, and the American Rescue Plan Congress provided $9 billion to states, tribes, and localities to respond to mental and behavioral health needs.

And last year the House passed nine additional bills that were shepherded through this committee that would support the mental health needs of health care providers and students, address inequities in services, and support access to the National Suicide Prevention Lifeline and its new 988 dialing code that launched this summer. And the House-passed Build Back Better Act would provide an additional 175 million for a range of mental health, workforce, and community services.

These are crucial steps in the right direction, but our work is not done. So as we spend more time online on social media digital platforms, that is going to continue to play a role in people's mental health, and especially our children. So we have to do more to understand both the benefits and risks of this reality with social media, as well.

So let me just conclude by saying the committee is also working to reauthorize a wide range of substance abuse and Mental Health Services Administration programs that expire in September. And as we conduct this work, it is important that we hear from people experiencing mental health challenges and the experts.

So I think this hearing is very important today, Madam Chair, and I want to thank all the witnesses as we look forward to hearing their experiences and their expertise. With that, I yield back.

[The prepared statement of The Chairman follows:]

**********COMMITTEE INSERT**********

*Ms. DeGette. Thank you so much, Mr. Chairman. The chair is now pleased to recognize the ranking member of the full committee, Mrs. McMorris Rodgers, for five minutes.

*Mrs. Rodgers. Good morning. Thank you, Madam Chair. Today's hearing is extremely important. It is long overdue.

COVID has taken a toll, especially on our children. Our kids are in crisis. A 2020 survey of 3,300 high schoolers found about a third of them unhappy and depressed. From March 2020 to October 2020, mental health-related emergency department visits increased 24 percent for children aged 5 to 11, and 31 percent for those ages 12 to 17. And we have seen about a two-and-a-half-fold increase in emergency department visits for suicides and self-harm among children under the age of 18.

Why? Not because of a virus that poses very little risk to children. The reason -- and I want to be very clear about this -- is the government's response to COVID. School closures, forced masking, lockdowns, and isolation all have driven the severity of the mental health crisis.

More than 40 public school superintendents from eastern Washington are calling for an end to the mask mandates on children. I join in appealing to both Governor Inslee and the CDC to listen to them. Trust the parents, the children in our schools who are saying, "Stop the madness.'' As the schools wrote, government restrictions are having, "an

exceptional psychological and social toll on our entire communities.''

It begs the question: Why are elected officials and unelected public health bureaucrats not responding to their pleas?

Schools must be open for in-person learning, with no mask. We must retire this notion of virtual learning. They are not learning. If a school goes virtual, it is closed. Children need to be in school to learn, to socialize, to develop emotionally. Children shouldn't be treated like vectors of disease.

The forced masking, which is undermining the benefits of being in the classroom, cannot be a condition for in-person learning anymore. Europe's CDC does not recommend young kids mask in school. The World Health Organization and UNICEF both recommend against masking children under five, citing the safety and overall interest of the child. And when considering masks for children ages 6 to 11, they actually consider other factors like the ability to learn and socialize.

I have raised this many times with the CDC Director Walensky. She is narrowly focused on COVID, which we all know is a virus that poses a lower risk to unvaccinated children than some fully vaccinated adults, yet CDC continues to rely on discredited studies to force a masking agenda.

You know, this week, I asked her, I asked Dr. Walensky what data she is relying on for the continued forced masking in our schools, and she cited a flawed Arizona study three times.

What have the experts said of this Arizona study? That it is so unreliable it should have never been entered into the public discourse. So why does she refuse to listen? Is it because of the corrupted relationship with Randi Weingarten and the teachers union? I don't know. Is it political? Is she following directions from the White House?

What I do know is that these guidelines are standing in the way of what is best for millions of Americans, and is not based on science or data.

Just this week, just this week we saw tens of thousands of people enjoy the Super Bowl unmasked in LA. But for the kids in that same city, they are forced to continue to mask. How can anyone justify this?

And now, suddenly, we see Democrat governors and mayors lifting their mandates. It doesn't seem to be based on science. Maybe political science.

But just six months ago, the Department of Education, President Biden's Department of Education, opened civil rights investigations into five Republican-led states who were fighting for children to be able to attend school unburdened by masks. We haven't seen the same action against

the Democrat-led states at this time.

I understand that updated mask guidance is coming. We must unmask our children. There is no excuse as to why these restrictions should not -- they should be the last to have the restrictions to be lifted.

You know, I am speaking for millions of Americans and parents across this country. I speak for them. I speak for my own son, who is still masked in his school. Children are our future. We all recognize that. These are bad policies that are a part of our sacrificing a generation of children and their future. Let's stop the suffering. Let's stand on the side of parents and kids, and make sure we get our kids back in school. And it is best for them, it is best for their mental health, it is best for our future.

[The prepared statement of Mrs. Rodgers follows:]

**********COMMITTEE INSERT**********

*Mrs. Rodgers. I yield back.

*Ms. DeGette. The chair now asks unanimous consent that members' written opening statements be made part of the record.

And without objection, they will be entered.

I would now like to introduce our witnesses for today's hearing.

Dr. Lisa Fortuna, who is with the American Psychiatric Association Member, and the vice chair of psychiatry at the University of California, San Francisco.

Dr. Jacqueline Nesi, assistant professor of psychiatry and human behavior at Brown University.

Amit Paley, who is the CEO and executive director of The Trevor Project.

Christopher Thomas, who is the co-founder of The Defensive Line.

And the Honorable Dr. Elinore McCance-Katz, who is the former secretary for mental health and substance abuse.

I want to thank all of you for appearing before the committee.

And I know you are all aware the committee is holding an investigative hearing, and when doing so has the practice of taking testimony under oath. Do any of you have an objection to testifying under oath today?

Seeing no objection, let the record reflect that the

witnesses have responded no.

The chair then advises you that, under the rules of the House and the rules of the committee, you are entitled to be accompanied by counsel. Does any of you wish to be accompanied by counsel today?

Let the record reflect that the witnesses have responded no.

And so, if you would, it is always a little different, but we are -- but we do swear witnesses in over Webex. Please raise your right hand, and -- so that you may be sworn in.

[Witnesses sworn.]

*Ms. DeGette. Let the record reflect that the witnesses have responded affirmatively.

And you are now under oath, and subject to the penalties set forth in title 18, section 1001 of the U.S. Code.

At this time, the chair will recognize each witness for five minutes to provide their opening statement. And as a reminder, you can see there is a timer on your screen that will count down your remaining time.

Dr. Fortuna, you are recognized for five minutes. And thank you again for being with us.

TESTIMONY OF LISA FORTUNA, M.D., M.P.H., AMERICAN PSYCHIATRIC ASSOCIATION MEMBER, VICE-CHAIR OF PSYCHIATRY, UNIVERSITY OF CALIFORNIA SAN FRANCISCO; JACQUELINE NESI, PH.D., ASSISTANT PROFESSOR OF PSYCHIATRY AND HUMAN BEHAVIOR, BROWN UNIVERSITY; AMIT PALEY, M.B.A., CEO AND EXECUTIVE DIRECTOR, THE TREVOR PROJECT; CHRISTOPHER THOMAS, CO-FOUNDER, THE DEFENSIVE LINE; AND HON. ELINORE MCCANCE-KATZ, PH.D., M.D., FORMER ASSISTANT SECRETARY FOR MENTAL HEALTH AND SUBSTANCE ABUSE

TESTIMONY OF LISA FORTUNA

*Dr. Fortuna. Thank you. Chairwoman DeGette, Ranking Member Griffith, and distinguished members of the Energy and Commerce Oversight and Investigation Subcommittee, thank you for allowing me the opportunity to serve on today's panel.

My name is Dr. Lisa Fortuna, and I am a professor of clinical psychiatry and vice chair at the University of California, San Francisco Department of Psychiatry and Behavioral Sciences. I also serve as the chief of psychiatry at the Zuckerberg San Francisco General Hospital, the public hospital for the city. I thank you for having me here today to address my issues surrounding the state of our nation's mental health. I am testifying today in my capacity as a member of the American Psychiatric Association.

The COVID-19 crisis, as we know, is exacerbating

anxiety, depression, and other mental health and substance use conditions. It has likewise unmasked and compounded existing racial and economic inequities within our health care system. I have seen the results manifest themselves in my leadership role, but also in my practice.

Earlier in the pandemic, I saw a patient who is a nursing home aide and a mother. Let's call her Gloria. During the early days of the pandemic, Gloria was forced to stop working in her home health job because she was afraid of catching COVID-19 and getting her children sick. Though Gloria left her job, her brother, also an essential worker, unfortunately caught COVID, and required care in an intensive care unit. He was unable to work for over six months because of his COVID-related disabilities. And over the course of six months, the same family experienced six COVID-related deaths in their extended family due to similar situations.

Gloria's 11-year-old daughter developed severe anxiety because she was afraid that her mother would catch COVID and pass away as a result of her job. As Gloria's daughter suffered from these untreated mental health conditions, Gloria too, between the stress and the grief of losing family members, suffered a relapse of major depression.

The stress and anxiety and grief from the pandemic have very real mental health repercussions for this one family, and they are not the only ones. And these health conditions

also had a complete domino effect on their economic stability.

Fortunately, Gloria's family was able to reach out to their primary care doctor, who connected them with a therapist and psychiatric consultation, and they were able to receive mental health services through tele-psychiatry, as well as other social services to help with food insecurity until Gloria was able to start working again.

The challenges of Gloria and her daughter are, unfortunately, not unique. As detailed in the December 2021 Surgeon General's advisory on youth mental health, depressive and anxiety symptoms for youth have doubled during the pandemic, while emergency room visits for suspected suicide are likewise increasing at alarming rates.

The mental health crisis for children has become so severe that last October, as you may know, the American Academy of Child and Adolescent Psychiatry, the Children's Hospital Association, and the American Academy of Pediatrics took an unprecedented step of declaring a national emergency in children's mental health.

As families like Gloria's continue to grapple with the direct and downstream effects of the pandemic, we encourage the committee to pursue policies that promote access to needed behavioral health services, with particular focus on extended care to vulnerable populations, including racial and

ethnic minorities, and LGBTQ-plus youth, among others.

As I have laid out and expand upon in my written testimony, Congress can take several immediate steps to support families like Gloria and address the ongoing mental health crisis.

One key area, which I will be happy to answer more questions about, is the importance of telehealth, and how that has been a godsend to families like Gloria and many others during the pandemic.

And the APA also has many other recommendations that I would be happy to talk further about that really are about increasing access, including extending the telehealth flexibilities authorized under the COVID-19 public health emergency, prioritizing health equity and workforce building programs to address existing shortages in our workforce in mental health, supporting policies and funding that help Federal and state enforcement agencies bring insurers into compliance around parity, apply parity requirements to Medicare, and ensuring that states and local communities are prepared for the launch of the 988 crisis line, and further incentivizing primary care practices for collaborative integrated care.

So I appreciate the opportunity, and I look forward to answering any questions about these issues.

[The prepared statement of Dr. Fortuna follows:]

**********COMMITTEE INSERT**********

*Ms. DeGette. Thank you --

*Dr. Fortuna. Thank you.

*Ms. DeGette. -- so much, Doctor. I am now pleased to recognize Dr. Nesi for five minutes.

Doctor, thanks also to you for being with us.

TESTIMONY OF JACQUELINE NESI

*Dr. Nesi. Thank you, Chair DeGette, Ranking Member Griffith, and members of the subcommittee. My name is Dr. Jacqueline Nesi, and I am a clinical psychologist and an assistant professor at Brown University. I study the impact of technology and social media on adolescent mental health.

Our nation is facing a mental health crisis among youth. Rates of depression, anxiety, and suicide have increased over the past two decades, and this crisis has only been intensified since the start of the COVID-19 pandemic. These rising rates of mental health concerns have coincided with another trend: the widespread adoption of social media.

Today nearly 97 percent of teens use social media platforms like TikTok, Instagram, YouTube, and Snapchat. Technology use has further increased during the pandemic, with adolescents now spending an average of seven hours per day using screens. These co-occurring trends of increasing social media use and rising mental health diagnoses have led to concerns about a potential link.

Is social media use causing mental health problems? Unfortunately, the current state of the research does not provide a simple, definitive answer. What we know is that the relationship between social media use and mental health is complex. We also know that serious mental health concerns

like depression, anxiety, eating disorders, and suicide are the result of a complicated interplay of genetic, developmental, and social factors, and cannot be attributed to a single cause. Social media alone does not cause mental illness in teens.

But does this mean that teens' use of social media is irrelevant when it comes to their mental health? It does not. Social media plays a central role in our children's mental health. To date, research suggests that the amount of time teens spend on social media is less relevant than what teens are doing online, and which teens are more susceptible to harm.

Social media offers opportunities and benefits for teens, but it also creates real risks and challenges, especially for those who are already vulnerable.

In terms of benefits, social media offers adolescents a forum for social connection, friendship, and creative expression. It offers critical opportunities for social support, especially among teens who may not readily have access to communities of supportive peers in their offline lives, such as LGBTQ youth. It can also provide education and awareness, and reduce stigma. For youth struggling with suicidal thoughts, social media can offer unprecedented opportunities for support, access to resources, and intervention during a crisis.

Despite these benefits, the potential risks of social media are significant. Social media provides an endless stream of photos and quantifiable indicators of social status -- likes, views, comments -- which may negatively affect youth self-esteem and body image. Night-time use of screens has been shown to interfere with youth sleep. Cyber victimization, or the experience of being bullied online, is another risk, and is associated with a range of mental disorders. Youth of color and LGBTQ youth are also disproportionately likely to be affected by hate speech online.

When it comes to suicide-related social media content, the dangers can be profound. Exposure to harmful suicide-related content has been shown to increase risk for self-injury over time. In extreme cases, youth may even encounter messaging that actively encourages suicide or self-harm.

But evidence-based guidelines exist for safer social media posting about suicide. Safe posts about suicide should provide messages of hope and recovery, include links to resources, or indicate that suicide is preventable. In contrast, harmful posts about suicide are those that glamorize, sensationalize, or romanticize suicide, those that trivialize it or blame it on a single cause, those that describe it as desirable, and those that provide details

about methods or locations of attempts.

More research is urgently needed to determine exactly how, when, and for whom social media is more harmful than helpful.

But one overarching conclusion can be drawn from the current body of work: social media is central to the mental health of young people.

Addressing the youth mental health crisis must be a multi-faceted effort, and ensuring access to services is a key component. Nearly half of adolescents with mental disorders do not receive needed treatment, with those numbers even higher among youth of color. Improving access to mental health care, such as through schools and primary care facilities, is vital. Helping youth use technology and social media in healthier ways must also play a role.

Legislators, social media companies, researchers, and other stakeholders can work together to maximize the benefits of social media for youth, while minimizing the risks. We can educate youth on the dangers of hate speech and bullying. We can help youth protect time for activities outside of screens. We can provide youth the opportunities to personalize their social media experiences, and give parents the tools to ensure their child's safety. And we can guide youth towards helpful resources and content, and limit access to harmful content.

Thank you.

[The prepared statement of Dr. Nesi follows:]

**********COMMITTEE INSERT**********

*Ms. DeGette. Thank you so much, Doctor.

I am now very pleased to introduce Mr. Paley for five minutes.

Mr. Paley, you are recognized.

TESTIMONY OF AMIT PALEY

*Mr. Paley. Subcommittee Chair DeGette, Ranking Member Griffith, and members of the subcommittee, thank you for the opportunity to testify today. My name is Amit Paley, and I am the CEO of The Trevor Project, the world's largest suicide prevention and mental health organization for LGBTQ young people. We offer free 24/7 crisis services for LGBTQ youth, and The Trevor Project last year served more than 200,000 calls, chats, and texts.

This is not a partisan issue. Any time we talk about the national mental health crisis, we need to all remember how deeply it impacts young people, and these past two years of the pandemic have only created new struggles. America's young people need Congress to act.

More than 1.8 million LGBTQ young people seriously consider suicide every year in the United States, and CDC data shows that LGBTQ young people are more than four times more likely to attempt suicide than their peers. We estimate that at least one LGBTQ young person attempts suicide every 45 seconds in the United States. LGBTQ young people are not inherently prone to suicide because of their sexual orientation or gender identity. They are placed at significantly increased risk because of how they are mistreated and discriminated against in society.

According to our 2021 national survey of 35,000 LGBTQ young people across the country, 70 percent said their mental health was poor most or all of the time during the COVID-19 pandemic, but nearly half could not access the mental health care that they need.

The Trevor Project is on the front lines of the national mental health crisis, and our counselors hear every single day from young people who have been negatively impacted by the COVID-19 pandemic, by recent politics, and a wide range of instances of anti-LGBTQ victimization.

But we have also seen rays of hope in the midst of this crisis. The Trevor Project is proud to have helped lead the effort to pass the National Suicide Hotline Designation Act in 2020, which established 988 as the new 3-digit code for the National Suicide Prevention Lifeline. This legislation was passed successfully due to overwhelming bipartisan cooperation and a unified focus on suicide prevention. Many of you championed the bill. The Trevor Project appreciates your leadership, and we are excited to work with you all to fulfill [inaudible] lifesaving promise.

SAMHSA has invested nearly $850 million in strengthening local crisis call center capacity and efforts to scale up the lifeline. And Congress is poised to appropriate $7.2 million for specialized services. However, time is running short. Formal agreements and funding have yet to be finalized, and

it is not clear that essential specialized services will be ready for LGBTQ young people in July.

In particular, it is crucial that 988 specialized services include establishing an integrated voice response option, which would enable LGBTQ young people to be transferred to groups like The Trevor Project, where we have our own specially and highly-trained counselors. This would also help take some of the burden off of the National Lifeline call centers, as call volumes are expected to dramatically increase.

I urge this subcommittee to utilize its oversight authority to ensure that congressional intent is being followed, and that the Administration is providing the funds promised, and taking all actions necessary to address the needs of all Americans, including LGBTQ young people, as quickly as possible.

I want to conclude with a final statistic, that having just one accepting adult in an LGBTQ young person's life can reduce their risk of suicide by 40 percent -- 4-0, 40 percent. All of us here today, each of you, can be that person, and can help save lives. We each have the power to make the world a more accepting place, and to show our children, all of them, that they are deserving of love and respect, and that they are not alone.

Subcommittee Chair DeGette, Ranking Member Griffith, and

members of the subcommittee, thank you for hosting this hearing and for your time today. The Trevor Project looks forward to continuing to work with Congress and the Administration in addressing the national mental health crisis and supporting our most marginalized young people.

[The prepared statement of Mr. Paley follows:]

**********COMMITTEE INSERT**********

*Ms. DeGette. Thank you so much, Mr. Paley. I met with some of my providers here in Denver the other day, and had a roundtable, and they gave that same statistic. One adult in someone's life can save them from suicide. So I think that is a good call to action that we should all follow.

Now I am really pleased to recognize Mr. Thomas for five minutes for your opening statement. Thank you, Mr. Thomas.

TESTIMONY OF CHRISTOPHER THOMAS

*Mr. Thomas. Good morning, Subcommittee Chair DeGette, Ranking Member Griffith, and members of the subcommittee. My name is Chris Thomas. I am the son of a high school dropout, and the first in my family to attend and graduate from college. I am here today as a survivor of 60 years. I am a survivor of sexual and racial abuse, as well as violence, poverty, and trauma. Unfortunately, along with my wife, Martha and my son Solomon, I am also a suicide loss survivor of my daughter, Ella.

In the face of this most profound loss and treacherous grief, my wife of 37 years, Martha, a middle school teacher with decades of experience, my son, Solomon, who was in his sixth year of playing in the NFL, and my niece, Ray, who possesses extensive social work and public policy experience, are speaking out today and every day about how we live. We are turning pain into purpose through our creation of The Defensive Line, with the vision of a world where no young person of color dies by suicide, the second leading cause of death for young people under the age of 24.

For young people of color, suicide [inaudible] and be a leading cause of death. The Defensive Line seeks to make a difference by reducing the stigma from sharing ours and other stories of loss and hope, by increasing connection to mental

health services in schools with a majority of students of color. We pursue this work through two programs: storytelling and advocacy, and suicide prevention workshops.

Reducing the stigma of mental health, mental illness, and suicide can only be combined discussing these challenges and what they look like in real people. We believe, by sharing our story publicly, we give these hard things faces, personalities, and relatability. Our suicide workshop aims to create solutions and enhance resource connections, referrals for youth.

We believe teachers and coaches play an essential role in young people's lives, and have the unique opportunity to see signs of suicide risk or mental health challenge before it gets to a point of crisis, which is why they are our focus.

Schools have resources for students, and we want to help everyone understand how they can play role in supporting young people's access to those resources.

Our workshops also focus on ways teachers may be creating unsupportive environments for some students through their own implicit bias by overlooking students of color's mental health needs because they look different.

The Defensive Line's mission is to end the epidemic of youth suicide, especially for young people of color, by transforming the way we communicate and connect about mental

health. The Defensive Line was established in May of 2021. Its genesis centers around the death, the impulsive suicide, of my daughter, Elizabeth Thomas.

Ella was born April 19, 1993. She was our first-born, and was born with a huge personality. From the womb she had determination, wit, and feistiness. Ella was never just another person in the room. Ella had that rare quality that we call presence. It is called charisma, as well, but it is always associated with leadership. She gave until she could give no more. On the day Ella took her own life, a police officer handed my wife her phone to show the last text that she sent before she died. Two of her friends were struggling with depression, and she was helping them save their own lives.

After losing Ella to suicide, my family and I learned about suicide prevention. What we wish we had known prior to losing her -- what we want others to know. There are signs a person experiencing suicidal crisis may show, such as giving away prized possessions. About a week before Ella took her life, she came to me and said, "Dad, you can take care of my dog, Mickey.''

As we speak, this Thursday, February 17, 2022, there will be 17 people under the age of 24 that will die by suicide. That equates to 119 people that will die by suicide every week, nearly what about Boeing 737 holds. I have to

believe, if a plane went down every week in America, Congress would take -- work together and create immediate solutions to address the issue. Let's do that for suicide prevention.

We started this work because we felt compelled to speak when so many were silent. The Defensive Line is an answer to the challenges of accessing mental health resources for young people. We are the bridge to resources. We believe everyone has a role in ending the suicide epidemic. Everyone can have a better understanding of the warning sign to look for and learn how to engage with others to have hard conversations. If people don't know when someone needs help, how can they get them help?

We believe mandating, standardizing, and funding K-through-12 suicide prevention curriculum, with a mandated annual certification for educators would play a significant role in preventing suicide deaths.

Our love is with Ella forever. We will work to ensure what happened to Ella doesn't happen to others. But we can't do it alone. We hope you will join us in this Defensive Line to protect, defend, and ensure the health and wellness of the brilliant future for our young people.

Thank you for this extraordinary honor. Ella would be proud. Thank you.

[The prepared statement of Mr. Thomas follows:]

**********COMMITTEE INSERT**********

*Ms. DeGette. Thank you so much, Mr. Thomas, for sharing your powerful story, and for your testimony today. It means a lot to this committee.

I am now really pleased to recognize Dr. McCance-Katz for five minutes for your opening statement, Doctor.

TESTIMONY OF ELINORE MCCANCE-KATZ

*Dr. McCance-Katz. Members of the subcommittee, thank you for the opportunity to speak about the current mental health crisis in the United States.

The COVID-19 pandemic has caused unprecedented stressors to be experienced by the American people. Mitigation strategies put in place to try to reduce disease and death related to viral infection were important, but unfortunately lacked a balanced approach that considered all health and mental health needs of people. Millions lost their employment and their income, experiencing great financial stress. All experienced the inability to participate in so many activities that give meaning to our lives. Millions contracted this illness, and hundreds of thousands died, contributing to fear, anxiety, and depression.

As we emerge from the pandemic, these situations have resulted in what is now a mental health crisis, one that for many is fueled by substance abuse and addiction. I believe that, to a great extent, this could have been avoided. I say this because there existed a literature that told us the mental health costs of isolation and quarantines.

This review of scientific studies published just prior to the start of COVID-19 mitigation programs in the United States told us that people experienced mental health effects

following as little as nine days of isolation. For health care workers studied after required isolation periods following exposure to an infectious agent, quarantine was the factor most predictive of the development of symptoms of acute stress disorder, anxiety, irritability, and reluctance to work.

As an aside, this study also laid the foundation for what we are seeing today: an exodus of health care workers over the course of this pandemic. For some, alcohol abuse was found to be long-term, as much as three years after quarantine. Many subjected to such restrictions remained reluctant to re-engage in normal life activities following quarantine. For example, ongoing avoidance of public spaces. The most severe symptoms were in those with the history of psychiatric disorder. And the longer the quarantine, the more severe the symptoms.

As we look to understand the current situation, SAMHSA's National Survey on Drug Use and Health showed that substance use disorders fully doubled in 2020 from pre-pandemic 2019 data, a 100 percent increase. Although SAMHSA caveats the findings because of updating the system to use current diagnostic criteria, it is important to note that this survey is a household survey, which means it does not capture data from some groups that we know have high rates of substance use disorders: the homeless, those incarcerated, people

living in institutions. So the National Survey on Drug Use and Health potentially underestimates the extent of substance abuse issues in our country.

As a further indicator of the severity of illicit drug use issues nationally, one only need to look at the substantial increases in deaths from drug overdoses in 2020 relative to 2019, an increase of nearly 30 percent, year over year.

Further, there was a 20 percent increase in alcohol sales during lockdowns relative to 2019. That is at-home drinking, often in isolation.

The data on increases in substance use and misuse is important because of the intersection of substance use and mental disorders. Co-occurring disorders -- that is, simultaneous occurrence of mental and substance use disorders -- are increasingly common. Substance abuse induces changes in the brain that are often associated with depression, anxiety, and psychosis. Those with preexisting mental illness or vulnerability to mental illness who use substances will experience more severe episodes. Combined stressors of social isolation and disease-related fears occurring in the context of large increases in illicit drug and alcohol availability have contributed to an upsurge in substance use and mental disorders.

I want to emphasize that legislation passed by Congress

to address the pandemic was key to maintaining mental health care when our health care system was essentially closed. For example, making medical care available by telehealth, including use of the telephone, preserved access and ongoing care, while reducing stigma, particularly for drug users needing treatment. The ability to make FDA-approved medications for opioid use disorder more easily available saved lives.

It is my hope that Congress will permit these innovations to stay in place with guardrails to diminish risk of fraud. Designing systems where patients have an option for hybrid telehealth and in-person visits should become permanent.

As our country opens up again, we must make treatment resources available to those in great need. Fully addressing the brain diseases that are mental and substance use disorders require psychiatric medical treatment. And knowing this, we must take immediate action to reconstitute the behavioral health workforce necessary to provide psychiatric and social services to help Americans recover from these illnesses.

In the future I think it is a certainty there will be more pandemics. As a nation, we should review actions taken over the past two years, determine what has been effective and what has not. We should learn from our experiences, make

behavioral health a national priority. Recognize that consideration of behavioral health needs must be part of any pandemic response, and prepare now for the next pandemic. Thank you.

[The prepared statement of Dr. McCance-Katz follows:]

**********COMMITTEE INSERT**********

*Ms. DeGette. Thank you so much, Doctor. I appreciate it.

It is now time for members to ask questions, and I want to reiterate, since all of the witnesses are appearing remotely today, let's make sure that everyone in the hearing room and online has their microphones on mute unless they are asking questions. And the chair will now recognize herself for five minutes.

As we have heard from the testimony from all of our wonderful witnesses today, there is no single problem with mental health in this country. And so therefore, there is no single solution. Congress has made a lot of investments. We need to look at a multi-faceted way to support Americans' health and well-being.

And so, given the range of experts and experiences among the witnesses today, I want to ask you -- you can think about it while the others are answering -- what key action you think Congress should take to address this crisis.

Mr. Paley, I am going to turn to you first. Briefly, what do you think is the most important action Congress can take now to address the mental health crisis in America?

*Mr. Paley. I think one of the key actions that Congress can take is making sure that all Americans have access to care and support when they need it.

There are a wide range of ways to do that, but one that

I want to highlight is making sure that 988 is fully funded and fully prepared, because we know that it is a critical lifeline for so many Americans who often don't know where else to turn when they are considering suicide or experiencing a mental health crisis.

And it is important that we make sure not only that it is available to all Americans, but that those most marginalized and most at risk, including veterans, including LGBTQ young people, have specialized services available.

*Ms. DeGette. And they need to know about it, too.

Dr. Nesi, what about you?

*Dr. Nesi. Yes, so my expertise is as a psychologist, and really the science behind social media. So, you know, commenting on specific policy is probably outside of my domain.

But I will say that I think there are steps we can take when it comes to social media to better serve youth. Just to that I will highlight I think that there is a lack of information and, really, awareness among the public about these issues. And so educating the public, including parents, teachers, teens themselves on safer and healthier ways to engage with social media, I think, is critical.

I also think there are difficulties in conducting research on this topic, and that we need more research to better understand these issues.

So those are the two things I can --

*Ms. DeGette. Great, great, thank you so much. That is helpful.

Dr. Fortuna, how about you? What one thing do you think Congress can focus on to really help address this crisis in a meaningful way?

*Dr. Fortuna. I think -- yes, we know it is multi-factorial, but I would say the -- one of the key issues is access, and that has to come through different interventions and venues.

So for example, that is why the APA -- and I am completely behind this, as well -- is the importance of telehealth access and mental health services wherever individuals reside. More mental health services within their communities that are culturally competent, and responsive, and accessible to all people. So that includes in primary care, in schools, where kids are all the time, and that we can rapidly have them have access to either in-person or telehealth services.

So I think expanding and making sure that there is access, and also including the workforce is critical.

*Ms. DeGette. Yes, yes, workforce is important.

Dr. McCance-Katz, what about you, briefly?

*Dr. McCance-Katz. Yes, thank you. I would say that, if Congress would preserve and expand the Certified Community

Behavioral Health Clinic program, that is an evidence-based practice of integrated care. It includes mental health, substance use disorders, and physical health care in one setting.

But importantly, it includes 24/7 crisis intervention services. People in mental health crisis should not be seen in emergency departments. It is not the right setting. It causes them to not get treatment, to be further stigmatized, and to spend many days languishing often. So these kinds of services are directed towards people in great need.

*Voice. It is also --- the impetus is on --

*Ms. DeGette. Okay, we need to have everybody mute now. Thank you.

Thank you so much, Doctor.

Mr. Thomas, I am going to finish with you because, as a parent, you have seen this firsthand. So here you have your opportunity to talk to people who are making the public policies.

*Voice. Yes, I think it will --

*Ms. DeGette. What do you think we can do -- after this person mutes -- what do you think we can do to make sure that we can prevent suicides like the terrible, terrible death of your daughter?

*Mr. Thomas. Thank you for [inaudible]. I agree with everything everyone else has said, but I think the key thing

is mandating and standardizing and funding K-through-12 suicide prevention curriculum.

There are some states that you can just show a five-minute video, and it ticks the box for suicide prevention. That is the critical part, mandating, and funding. This was a key piece, as well as developing awareness and legislative platforms to generate a public discussion and normalizing the conversation about suicide, as well as mental health. Because the more we talk about it, the more we normalize it, and the more it helps us create culturally competent care -- access culturally competent care, which is an important piece.

*Ms. DeGette. Thank you so much. I now am pleased to recognize the ranking member for five minutes, Mr. Griffith.

*Mr. Griffith. Thank you very much, Madam Chair. I just want to quickly respond to something that Chairman Pallone mentioned in his opening statement. He referenced a Department of Labor finding that insurance companies are out of compliance with a law that requires them to deliver parity for mental health benefits, and we all want that.

But it is true that all the comparative analyses were initially insufficient. Initially. But my understanding is that the DoL has yet to give plans the guidance they need in order to be in compliance. And it is not just me. Secretary Walsh agrees. The Department of Labor has said they will

issue a notice of proposed rulemaking to provide that additional guidance to payers by July of this year. The need for this guidance is acknowledged in the very report that the chairman referenced.

I look forward to reviewing the new regulations before concluding that the current authorities are intentionally insufficient, that -- they are trying, I hope. And if they aren't, they will have to do something.

Dr. McCance-Katz, there has been a lot of discussion among members of our committee about the mental health of school-aged children. That said, there has not been nearly as much conversation in the public discourse about the impact of COVID-19 restrictions on younger children and babies. But I am seeing growing evidence that their cognitive development may be affected by prevalent use of masks by caregivers, as is likely to be the case for babies and young children spending their days at daycare or preschool.

What is the role of face-to-face interaction in the normal development of infants and toddlers?

*Dr. McCance-Katz. So from the time that a baby is born, they make facial recognition with their caregivers. It is important to attachment between the caregiver and the baby. Babies learn facial processing, so they learn to recognize who their caregivers are. And they, from a very early age, start with social and emotional development that

is based on interaction, being able to look at the face of the caregiver, and the caregiver at the face of the infant.

I think it is -- it would be important to educate parents and caregivers about the need to interact with these very young children without masks. I know that we now have rapid testing available. We can use rapid testing to assure that the risk of COVID is very diminished. But it is important that families and caregivers in daycare centers, for example, and nurseries be able to also interact with babies and young children without masks.

*Mr. Griffith. And isn't it true it is not just the interaction, and knowing that the folks care for them, and seeing those facial expressions that -- and that is very important. But isn't it also true that it affects their ability on verbal skills, and motor skills, and overall cognitive skills when the people that they are with a big part of the day are masked?

*Dr. McCance-Katz. It -- yes, it is a concern. There is emerging research that indicates that children born during the course of the pandemic, when compared to children born earlier, have those kinds of deficits, and it is something that I think is not fully understood. And the literature is young, but we need to pay attention to that. It could very well be something to be concerned about for our children.

*Mr. Griffith. And Dr. McCance-Katz, you referenced

hybrid telehealth, and we all know that telehealth has been important during this. But you referenced hybrid telehealth, and I think I know what that means, but can you tell the folks back home? What does that mean, and why is that important that we have that?

*Dr. McCance-Katz. So what I am recommending is to keep telehealth in place, but to make it available in a number of ways.

So when we -- when CMS defined telehealth originally, they talked about audio-visual platforms. Well, millions of Americans don't have access to audio-visual platforms. They either can't afford to have an internet connection in their home, or they live in rural areas. And it is estimated about 25 percent of Americans living in rural areas do not have broadband access, and so the telephone --

*Mr. Griffith. And they need contact --

*Dr. McCance-Katz. -- becomes extremely important.

*Mr. Griffith. There you go.

*Dr. McCance-Katz. So --

*Mr. Griffith. And look, that is a lot of people in my district. And I am running out of time, so I hate to cut you off. I would love to have more discussion, but that is a lot of people in my district. So we need to make sure it is not just the audio and visual, but also the audio, so that people can at least have somebody they can talk to when they are

having mental health issues. I appreciate that.

I will say we also need more on substance abuse, and I want to commend Delegate Sam Rasoul, who is leading the charge in my -- he is just outside of my district, but leading the charge in my district for expansion by the state of Virginia at the Catawba Hospital for Substance Abuse Disorders. And I appreciate that.

And I yield back, Madam Chair.

*Ms. DeGette. Thank you so much. The chair now recognizes Mr. Pallone for five minutes.

*The Chairman. Thank you, Chairwoman DeGette. As I mentioned in my opening statement, despite congressional efforts that our committee led in 2019 to strengthen the enforcement of the Federal parity law, a recently-released report found that insurance companies are still failing to deliver parity for mental health and substance use disorder benefits. So let me start with Dr. Fortuna.

In your testimony you state that -- and I quote -- "Achieving full compliance with the parity law's requirements is essential, given the need to access and maintain coverage for mental health and substance use services.'' So, Dr. Fortuna, can you briefly discuss why mental health parity is so essential for patients, particularly in light of COVID-19, and some of the challenges they face in accessing services and care for behavioral health during COVID-19?

*Dr. Fortuna. Yes, thank you very much for that question. Yes, parity of mental health is critical.

You know, the laws have been put in place, essentially, to ensure that when individuals are experiencing a mental health crisis or a psychiatric disorder that requires treatment, that they are able to access that in equal ways, as they would if they were having a major medical crisis or medical condition that needs to be treated.

Often in our field we find that often people are rejected by insurance companies of being able to have adequate services because they are psychiatric. For example, being in an inpatient unit, and being said that no longer days will be covered because they have to be discharged because they are not getting better. And we wouldn't do that for any other medical condition, right, that you are not getting better, so you are discharged, or for substance use disorders that are not covered.

So for Americans to actually be able to access the services that they need, we have to consider psychiatric illnesses equally as important and necessary to receive treatment and to have the adequate coverage. Without coverage, people cannot receive care.

*The Chairman. But as I said, we know that, you know, the parity law, the insurance companies are not, you know, acting in accordance with it. So what additional steps do

you think are necessary to close the gaps that exist between coverage for mental health services and general medical care?

I mean, what should we be doing in Congress or otherwise in response to this report that shows that the enforcement is not there the way it should be?

*Dr. Fortuna. Yes, I mean, I think Congress should definitely support states to be able to have the resources that they need to be able to evaluate, investigate insurance companies, ensuring that they are in compliance with the parity laws. We think that that is essential at the APA.

In addition, there are some insurance, like Medicare and components of Medicare, that are not covered by the parity law. And that also, therefore, does not allow this protection over people who are particularly vulnerable with disabilities. So, you know, so advancing that in the Medicare population, as well, would be something that would be very important to also include and extend.

*The Chairman. Well, thank you. I know there is not a lot of time left, but I want to ask Mr. Thomas -- and my condolences to you and your family for your loss. And, you know, what -- the work you have done through Defensive Line is really saving lives, in my opinion, by helping de-stigmatize mental health issues.

So from your personal experience and your foundation, what -- you know, obviously, we are having discussions like

the one we are having today to help de-stigmatize mental health. Again, is there anything else you would suggest to help de-stigmatize mental health and encourage people to seek help?

*Mr. Thomas. Yes, I -- thank you for the question, and I really believe it is a focus on whole health, and making sure that we have the right care, the right access for people.

I know that for, like, my son Solomon, physical strength as an NFL player, but when my daughter Ella passed away, he went through his own mental health crisis, and it took extraordinary care and attention from his employer, the 49ers, and my wife, Martha, to recognize he was in pain. And he had to fight his way through the stigma to understand that it was okay for him to go seek help, and understand therapy and meditation and journaling were all ways to help him through the process.

So I think having discussions, platforms, communications in school and universities about the importance of whole health, and the fact that it is okay to not be okay, and it is okay to be vulnerable, and it is okay to not have this toxic mentality and masculinity, that that is going to be a key part of it.

And because I know that, for sure, if my wife, Martha, and I had seen the signs that AFSP puts up on talk --

behavior, we might have been able to help prevent Ella's passing.

*The Chairman. Thank you so much.

Thank you, Madam Chair.

*Ms. DeGette. Thank you so much. The chair now recognizes Mrs. McMorris Rodgers for five minutes.

*Mrs. Rodgers. Thank you, Madam Chair. Thank you, everyone, for being with us.

Dr. McCance-Katz, I have some questions for you. In early 2021 we started hearing some experts ringing the bell about the impact of school closures. And we heard some that were saying that the mental health crisis caused by school closures would be worse than the pandemic of COVID-19. Two years into this pandemic, I would love to hear your thoughts on that.

*Dr. McCance-Katz. Thank you very much for that question. I have to say that, in my role as assistant secretary, I was, you know, ringing that bell, if you will, from the very beginning, with the decisions to have extended lockdowns in the country, and to have extended school closures.

I think it is really important to note that children have been relatively unaffected by COVID-19, relative to other parts of our population. If we look at deaths from COVID, the great majority, about 74 percent, are in people

over 65. We have had well over 800,000 deaths. We have had less than 800 deaths in children. And while every death is a tragedy, relative to other age groups and risk groups, children have fared very well with the virus.

If we compare that, if we compare those numbers, children aged 5 to 19 had suicide rates in 2019 that were 3.4 times as high as the 2-year number of total COVID deaths of children in that age group. So this is -- I think this makes the case for just how devastating the social isolation of the extended periods of isolation have been for our children.

*Mrs. Rodgers. Thank you.

*Dr. McCance-Katz. And it was very predictable.

*Mrs. Rodgers. As I mentioned in my opening statement, the CDC and Director Walensky continue to cite a discredited Arizona study as the basis for forcing children to mask in schools, and there has been an Atlantic article that has showcased the problems with this study.

I wanted to ask if you were familiar with this study, and why you believe CDC continues to rely upon this study when it is -- we have very little data or science to highlight or underscore the benefit of masking in schools.

*Dr. McCance-Katz. Well, I am familiar with the study, and I think that the study has a couple of major problems, methodologically. One is there were differences in the observation periods for the different schools. And the

second is that there was no consideration of vaccination rates amongst children and staff in the schools. And that can bias, in terms of COVID outbreaks and the appearance of COVID outbreaks in schools.

It is really -- I don't know why CDC touts this study. I can't speak to that. I would just say that it is concerning that this study is being used as kind of the study that they go by, when they have another study that they funded that had over 90,000 children in it in Georgia that showed that masks were not a significant factor in COVID outbreaks in those schools.

*Mrs. Rodgers. Thank you.

*Dr. McCance-Katz. So I just don't --

*Mrs. Rodgers. Well --

*Dr. McCance-Katz. Yes, thank you.

*Mrs. Rodgers. I appreciate that insight. I have one final question that I wanted to ask, and -- because it is not only the masking in schools where we see, it seems like, cherry picking of data. The CDC has highlighted its data on a number of children between ages 5 and 11 who died from COVID over 2020, 2021. However, the CDC's own data from 2019, pre-pandemic, showed that three times as many children from ages 5 to 11 died from homicides that year, relative to the number of COVID deaths in the age group.

So I wanted to ask, do you think the numbers of

homicides in children will change over the course of the pandemic?

And do you think school closures play a role?

*Dr. McCance-Katz. Well, I think that this really underscores one of the real tragedies of the COVID mitigation responses and closure of schools, because schools are the source of mandatory reporters for children that are suspected to be victims of abuse and neglect. Homicides in children aged 5 to 11 are likely to be children who were abused. And so this underscores one of the true tragedies of the extended school closures.

And no, I do not think those numbers are going to go down. I think they are going to go up.

*Mrs. Rodgers. Thank you. Thanks for being with us. And thank you, everybody. My time is expired.

I yield back, thanks.

*Ms. DeGette. Thank you so much. The chair now recognizes Ms. Kuster for five minutes.

*Ms. Kuster. Thank you, Madam Chairwoman. I appreciate it. I very much appreciate the topic of this important hearing.

Life during the COVID pandemic was truly stressful. I had a -- someone yesterday that I was with from New Hampshire tell me that it is almost as though the entire country has experienced an adverse childhood experience over the past two

years, and I think it is no wonder Americans are reporting increased symptoms of anxiety and depression.

Some of the testimony that has been cited, evidence that has been cited, I think it is the fear of catching the disease that really was at the heart of it. And I think that spilled over to children, as well. I think a lot of children did just fine with masking, but I want to hear more, and learn more about it.

Even before COVID-19, our communities were battling an addiction crisis. And that is why in 2015 I founded the bipartisan Addiction and Mental Health Task Force to address this evolving epidemic. We were finally making progress, but COVID-19 has pulled back the curtain on the depths of that crisis, and substance use and overdose deaths continued to rise, exacerbated by an ongoing epidemic affecting millions of Americans.

Just yesterday I spoke with our Granite State YMCAs and learned that they are partnering with the local hospital in Nashua, New Hampshire, to bring more mental health services into the community. And this is just one example of the types of programs we need to support our communities because, unfortunately, the number of overdose deaths continues to climb. More than 100,000 Americans a year now die from drug overdose, a 30 percent increase over 2019. And sadly, this increase is infecting -- affecting some communities harder

than others.

A recent NIH-funded study found that opioid or stimulant deaths among Black Americans has risen at more than three times the rate among non-Hispanic, White people, especially in eastern states. So, Dr. Fortuna, you have researched the co-occurrence of substance use disorder and comorbid mental health conditions. How has the pandemic affected the substance use epidemic in this country, particularly in marginalized communities?

*Dr. Fortuna. Thank you for that question. It -- we -- as you have mentioned, the COVID-19 pandemic has completely exacerbated and escalated substance use problems that we are seeing in our community.

Just in San Francisco, which I can speak to very intimately, is -- in our homeless population, which we serve as a public hospital, there have been more deaths due to overdoses as compared to COVID-19, which we were very worried about in our homeless population. It has doubled to tripled the rates of death. Where we were having maybe 60 deaths a week at one point during the pandemic, they were secondary to overdose.

And part of that has been the escalating stressors that people have been experiencing throughout the pandemic, so it is something that interacts. But it is also the issues that we have had in terms of being able to provide continuous

access and services to substance use treatment throughout the pandemic. So that is another piece that we haven't spoken as much about, in terms of how certain services were closed or inaccessible for periods of time throughout the pandemic.

As a public hospital, we were very involved in making sure that we sustained that. Some of that was through telehealth, believe it or not, and audio contact with patients. We have had -- we had patients that only could use audio for us to be able to access. I mean, we did a lot of street outreach and work, but some people we could only reach through audio, and we had people who actually offered technology so that people could have phones and could remain in contact with their treaters. And that prevented some overdoses in many cases.

And there are many, many other things that we are trying to implement, because there has definitely been escalation in that, and it really does relate to serious mental illness and the combination with co-occurring substance use disorders in the --

*Ms. Kuster. Thank you. I am sorry, I have to move on.

*Dr. Fortuna. Yes.

*Ms. Kuster. But we are going to be working on that with the audio and telehealth. So we appreciate that. I want to turn quickly in the final seconds here to Mr. Paley.

The Trevor Project published resources demonstrating

higher substance use among LGBTQI youth and young adults. What factors do you think contribute to that, if you could, just in the final seconds?

*Mr. Paley. I appreciate you calling attention to that. We need more data, frankly, to better understand what is happening. The government needs to collect better data on sexual orientation and gender identity.

But we know that many of the same factors that create mental health issues -- victimization, discrimination, and lack of acceptance -- are many of the reasons that LGBTQ young people face a number of the mental health and substance abuse challenges. So that statistic about more acceptance and support and access to care, those are all things that can help lead to better outcomes for LGBTQ young people.

*Ms. Kuster. Thank you. And I see a lot of nodding by Mr. Thomas, so we will follow up on that. Thank you.

And with that, I yield back.

*Ms. DeGette. I thank the gentlelady. The chair now recognizes Mr. Burgess for five minutes.

*Mr. Burgess. And I thank the chair. I really do just want to underscore Ranking Member Griffith's comments about parity.

This committee has worked on this, as Chairman Pallone knows, really, going back over a decade. And it was our committee who worked on Patrick Kennedy's bill, and it was

attached to the Troubled Asset Relief Program back in 2008. Of course, the Affordable Care Act and including mental illness under the category of essential benefits, that had to be covered, and I think that was 2012 when that rulemaking finally came down. And yet here we are, 2022, still awaiting the final rulemaking. So this is important, and I do think it would be critical that this committee stay focused on that because, clearly, leaving it to the agency themselves, it has languished, and it is clearly important.

Also, what Ranking Member McMorris Rodgers alluded to with the masks on children. Forever it is going to be ingrained as an [inaudible] moment, that elementary school class, when the teacher told them that they no longer had to wear masks, the unbridled joy of those children. I mean, that is, to me, that -- if you needed a punctuation mark for the end of the pandemic, that was it. And certainly, we need to acknowledge the relief that those children felt by having been told that their masks were no longer necessary.

Dr. McCance-Katz, I want to thank you for being here. You have been in our committee before. You have always provided very useful testimony.

Your reference to the article in The Lancet about the effects of isolation and subsequent mental illness, I -- you know, I am just really taken by the fact that you said that some of this could have been avoided.

And I do remember the early days of the pandemic, back in late January, early February 2020, when public health people who you would recognize would come before us and talk. And in fact, the comment was made that this is a SARS virus, similar to what SARS was before. And in 2022 we beat SARS with quarantine and contact tracing. But I don't know that anyone gave proper attention to the effects of quarantine, particularly if it was going to be prolonged.

Was this ever part of the discussion in the Administration in the early part of the pandemic?

*Dr. McCance-Katz. It was part of the discussion. I was talking about this from the very beginning. And I think that this was such a terrible virus, there were -- there was such fear of deaths, and the terrible illness that it -- that this virus caused, that people just couldn't consider what I was trying to say at that time.

And mental health was not part of the White House task force. I was invited to speak a couple of times at the task force, and I spoke each time about these issues. But again, the ravages of the virus on Americans was such that mental health just, I think, couldn't be considered at that time.

*Mr. Burgess. Yes, I get it. And it was. You are right. The virus was unlike anything people had seen before.

Let me just ask you. This nexus of homelessness, mental illness, substance use disorder, this committee worked on --

when we worked on the mental health title in the Cures for the 21st Century, there was a lot of discussion on the -- what is called the IMD exclusion, and perhaps pausing that, or doing away with that regulation.

Is that -- and that discussion was curtailed because of the expense of what that would be in a Congressional Budget Office score. But realistically, when you look at the expense of what cities and counties and towns are having to spend, keeping up with the problems with the homeless population, is there -- is it time to reevaluate that IMD exclusion?

*Dr. McCance-Katz. I think it is. My current position is running the state hospital in Rhode Island, and I am really seeing very severe mental illness. It is mental illness that really needs time on an inpatient setting in order for people to get the care that they need to recover.

The IMD exclusion is something that, if lifted, would allow us to provide people the care and treatment that they need, that will help them to avoid future hospitalizations, particularly in combination with some of the other programs that Congress has helped us to put in place.

*Mr. Burgess. Very good. Well, I appreciate that answer. I will --

*Ms. DeGette. Thank you so much, Mr. Burgess.

*Mr. Burgess. Thank you.

*Ms. DeGette. Mr. McKinley?

Or, I am sorry, Ms. Schakowsky, you are recognized for five minutes.

*Ms. Schakowsky. Thank you, Madam Chair, for holding this important, very important, hearing. You know, on Tuesday I went to a really devastating funeral of a 19-year-old girl who committed suicide.

You know, I want to discuss one of the paths that seems to lead to suicide in too many instances -- actually not in this case -- have been things that happen on the internet. In December I had a hearing in my Subcommittee of Consumer Protection and Commerce, and we had -- we heard from the whistleblower, Frances Haugen, who talked about some of the dangers there for young people, even though Facebook had made promises, had, you know, its own statements that it doesn't lead to these kinds of harms.

I think the time has come that the internet needs to be regulated in a way that keeps our kids, in particular, safe. And there are -- I have introduced legislation, and Kathy Castor has introduced legislation, and we need to move on it.

But we also heard testimony about a girl named Leona -- let's see -- Anastasia Vlasova, who got hooked on Instagram, on these images, perfect images of girls' bodies and girls' lives. Anyway, it ended up that she had a very, very serious eating disorder.

And so, you know, despite the, you know, the bans and the promises and the apologies, this still goes on. And so I wanted to ask Dr. Nesi, can you speak to the risk and the harms of certain uses of social media, and how exactly those harms contributed -- contribute to mental illness and even suicide?

*Dr. Nesi. Yes, thank you for that question. You know, I think that, when it comes to things like suicide, these are really complex phenomenon. And so we know that there is a number of different factors that play a role. It is rarely one single cause.

And I think, when we think about the effects of social media, I think that right now the evidence would suggest that there is both benefits and risks. So, you know, when we think about the benefits for things like suicidal thoughts, it would be things like social support, getting access to resources, connecting with peers, which we know is essential.

But, of course, there are risks, as you say. So risks would be exposure to harmful content that might be related to suicide, cyber victimization, displacement of other activities that are important, things like sleep and exercise. And certainly, exposure to things like hate speech and discrimination, all of these things we know can play a role in the risks of social media.

*Ms. Schakowsky. But would you say that it is time for

the Congress to take a look at what kinds of things are allowed on the internet that certainly can have an adverse effect on -- especially on young people who get, you know -- because often they -- the platforms target and actually entice people to go into websites that are dangerous for them.

*Dr. Nesi. Yes. So, you know, I -- as my expertise is in the research on this subject, and not -- and so I won't comment specifically on policy here, but I do think that there -- we know from the research that, when teens are exposed to content like this, that it can be harmful. When they are exposed to content that is potentially even promoting suicide or self-injury, that that is clearly harmful to them.

*Ms. Schakowsky. So I also wanted to ask a question -- do I have time left -- about the LGBTQ community. And I just wondered if there are any online hazards that are there to our expert on that.

*Dr. Nesi. Yes. So when it comes to the LGBTQ community and use of social media, obviously, all teens are different, and the way they are using social media is different. And that is true of LGBTQ teens, as well.

We know that the benefits for those youth exists online, including opportunities to connect with peers that they might not have the opportunity to do in person. But we do see

risks, as well. And I think one of the key risks we see there is exposure to discrimination and hate speech, to homophobic content, things like that.

*Ms. Schakowsky. Yes, bullying online is really a hazard.

Thank you so much. I yield back.

*Ms. DeGette. I thank the gentlelady. The chair now recognizes Mr. McKinley for five minutes.

*Mr. McKinley. Thank you, Madam Chairman. I think on this subject, and I have really enjoyed the conversation with the panelists and what they have contributed. But on this one subject I think we can all agree that, in our classrooms, our children all across America are suffering from this combination of mental health and substance abuse.

So I don't expect any answers from everyone on the panel, but I would hope that they would get back to our offices, if they would. But I want to direct some of my questions primarily to Secretary McCance.

And let me just start with saying that teachers across -- they are trained, and they are certified to teach. But we are asking them to also get involved in counseling, nutrition, and identifying autism. This distracts from their trying to teach. So my question would be, would we be beneficial to having -- encouraging mental health counselors in each of our schools across America?

Is there -- could you address that, that subject, briefly?

*Dr. McCance-Katz. Yes, thank you, Representative McKinley, and it is nice to talk to you again.

It is very important that we put resources in our schools. We have a history of doing that. Teachers, I agree with you, are being asked to do far too much. In our administration, we were so concerned about the needs for mental health services and substance use disorder services for students that SAMHSA and CMS actually put out a guidance to states and to communities and to school districts about how they could think about putting mental health services in place, and pay for it, get it paid for.

*Mr. McKinley. Thank you, thank you. If I -- I have got several other quick questions to follow back up with you on this, as well, but the other is classroom size.

Our teachers are often confronted with 25, 30 children in a classroom. So is there any evidence to suggest that smaller classroom sizes allows our education community to be able to identify these problems better, and do a better job for our children by having small -- is there any written evidence or white papers we could study about that --

*Dr. McCance-Katz. So this is not --

*Mr. McKinley. -- smaller classroom size?

*Dr. McCance-Katz. -- not my area of expertise, but I

believe that is the case, because I believe that classroom sizes -- they have worked to reduce classroom sizes for many years.

*Mr. McKinley. Okay, let's -- now, the other is -- once -- in a school, once we identify these children that have problems for a variety of reasons, in rural America we don't have the resources. This isn't New York or Seattle or St Louis. In West Virginia, our largest town in my district is 30,000 people. So how do we provide these services? Once we identify someone with autism, or someone with a mental health problem, or someone with an opioid addiction, how are we supposed to deal with that in rural America? What would be -- what would your suggestion be?

*Dr. McCance-Katz. So SAMHSA has a program called Project Aware. Project Aware provides resources to schools in many parts of the country. That program now allows behavioral health aides to be in the classroom, and that is an important piece of providing some mentoring and some support to students who are identified as having those kinds of needs. I think those kinds of programs should be expanded.

One of the things that I heard during my time of traveling around to schools was that there just were not enough counselors to -- and social workers to assist all of the children who need those services. So we need to train

more of these kinds of professionals, and we need to put mechanisms in place to pay for those people to be in schools and provide those services on site.

*Mr. McKinley. Thank you. Thank you. Now my last question for all of you, would -- what I would like -- what are some examples of real productive [inaudible] that have been tested in our school systems all across America that are working to address behavioral health problems, opioid addiction, nutrition problems, on and on?

Are there are there some models that we have seen work very effectively that we could be promoting throughout this country?

Any one of you could get back to -- I would like to -- you could follow back up with our office or, if you would like to add something quickly here in the few seconds I have left --

*Ms. DeGette. Mr. McKinley, maybe we can ask the witnesses to provide that written to the committee, because I think we would all like to see that.

*Mr. McKinley. Thank you. Thank you very much, Madam Chairman. I think it would be very helpful. Thank you. I yield back.

*Ms. DeGette. Thank you so much. The chair now recognizes Mr. Tonko for five minutes.

*Mr. Tonko. Thank you, Madam Chair. The pandemic

undoubtedly has had an impact on the mental health and well-being of many Americans. And the growing need for mental health services has [inaudible] access challenges already faced by many.

So, Mr. Thomas, you have been working --

[Audio malfunction.]

*Mr. Tonko. -- two of them under the cloud of this pandemic. So what have come up in your conversations?

*Mr. Thomas. I did not hear the question, I apologize. You are breaking in and out.

*Mr. Tonko. Oh, I am sorry --

*Ms. DeGette. Mr. Tonko, we are having some difficulty hearing you. I think you have got some reception issues.

*Mr. Tonko. Okay. Should I try it again?

*Ms. DeGette. You know, maybe what I will do, if it is okay with you, I will go to Mr. Ruiz.

*Mr. Tonko. Can you hear me now?

*Ms. DeGette. Oh, wait, I can hear you now. Yes, try it.

*Mr. Tonko. Okay, so Mr. Thomas, you have been --

[Audio malfunction.]

*Mr. Tonko. -- communities and awareness about mental health for several years, two of them under the cloud of the pandemic. What COVID-19-related mental health challenges have come up in your conversations?

*Mr. Thomas. If I heard your question correctly, it was about mental health challenges in the face of the pandemic, is that correct?

*Mr. Tonko. Well, that you have heard in your conversations, which -- maybe, Madam Chair, I will check on the technology here, so that -- I don't want to waste your time or mine here, lose my time. Can you come back to me after Dr. Ruiz, perhaps?

*Ms. DeGette. I am happy to do it, and I will recognize Dr. Ruiz for five minutes, and then you can work on -- we will give you five minutes when you figure out your technology.

Dr. Ruiz?

*Mr. Ruiz. Thank you, thank you. And Representative Tonko, I am sure he is dialing -- speed-dialing his Millennial in his office right now to come fix his tech for the tech support. So the best of luck to you, my friend.

Thank you, Chairwoman, for holding this hearing to address this important, critical topic. As a doctor who was in the emergency department during the H1N1 pandemic, and also in the front lines in Haiti immediately following the earthquake in 2010, you know, I understand through experience firsthand the mental toll of being a health provider in a crisis is [sic]. And I can only imagine how much greater the burden is for our frontline health workers who have been

fighting this battle, day in and day out, for two years now.

A recent survey of health care workers and first responders that was published in the Journal of General Internal Medicine tells a troubling story. Thirty-eight percent were suffering from PTSD. Seventy-four percent reported depression. Seventy-five percent were experiencing anxiety and fifteen percent had recent thoughts of suicide or self-harm. Yes, providers are professionals, they are trained, they put their heart and soul on, they put the patient above their own needs. And often times that is difficult.

But providers are also human, and they come home, and they think about the patients and the loss and the anxiety. They think about the vitriol that they see in the fighting in the communities for people who are against the simple measures of wearing a mask that would prevent the spread of the virus to others. And they think about the human toll that this has taken not only to those individuals, but in their own souls when they see such trauma.

And we are trained to not associate, not internalize. But at the end of the day, some -- there is loss of sleep, and there is a general mourning for the patients that we take care of. I know that because I experienced that in the emergency department, day in and day out.

Dr. Fortuna, we have seen the troubling data. But

through your hospital work these past two years, I imagine you have seen firsthand the mental health burdens facing health care providers. What additional mental health challenges are health care workers experiencing as a result of the pandemic?

*Dr. Fortuna. Thank you very much, Representative Ruiz, for this question. You are absolutely right. All those statistics are playing out where I see it here, even in San Francisco. It is our emergency, it is our front line, it is our ICU. And I like to underline it is also our psychiatry faculty and staff, who are also seeing a tremendous amount of loss.

Some of the things that are happening are -- is there is a tremendous amount of either all of those things -- PTSD, anxiety, depression -- or, at minimum, burnout, where -- you know, we did a recent survey, and found that over 60 percent of our physicians and nurses are presenting with some level of burnout and fatigue.

*Mr. Ruiz. I am glad you are mentioning this, because our country already has a physician shortage crisis.

*Dr. Fortuna. Right.

*Mr. Ruiz. And about a third of our doctors are over the age of 65, in retirement age. If you are an elderly doctor that is experiencing burnout due to this pandemic, then the likelihood that you will retire sooner than later,

it increases that risk because of that burnout. So that can dramatically worsen our physician shortage crisis and our provider crisis.

On top of that, if you de-incentivize the providers by cutting their payments to provide the basic services, or you have the insurance companies who can dictate the median rate of payment for the surprise billing dispute, you add even more stressors to our physicians and providers who have been heroes during the pandemic, and will accelerate their -- closing their doors, and the hospitals also closing.

So what steps should Congress take to close the gap between the demand for services and the supply of providers in dealing with the burnout and the mental health issues right now?

*Dr. Fortuna. I think there are several things. I mean, there is two components to that.

One is we definitely need to increase pathways for workforce, right? Which I will talk about, because you are absolutely right, people are retiring earlier, and people are just leaving the field. And we have a tremendous shortage of being able to have mental health providers. So, you know, there is a few things that can be done around workforce.

But let me just talk about sort of the piece around the burnout and mental health. One of the things that we instituted pretty rapidly was a program called COPE, which

was a program that allowed all of our staff, physicians and otherwise, to be able to access a line where they could screen for their mental health needs, and immediately connected with behavioral health services without any wait, and without any additional cost to them. If their insurance covered it, if the insurance didn't cover it, it didn't matter. We made sure that they got immediate access to mental health services.

So if there was a way for Congress to be able to institute and support resources for immediate mental health and support services for people in the health field, that would be fantastic, because we have to find multiple ways of doing that.

*Mr. Ruiz. Dr. Fortuna, often times a patient who is -- lives in a disadvantaged community lacks social capital and social networks, and that leads to a higher risk of anxiety and depression, based on living in an under-served area. And there have been some studies that show that the use of community health workers -- and in the Hispanic community they are often called promotoras --

*Dr. Fortuna. Yes.

*Mr. Ruiz. -- to providers in order to augment that social capital, and to help providers reach into the community to provide the counseling or the connection that they need with a professional.

In your experience, is that something that Congress should look into fostering with perhaps instituting reimbursements for that type of community service, aligned with the clinics and the providers?

*Dr. Fortuna. Yes, absolutely. And that -- some of the work that we are doing in using these community health workers, promotoras -- in some instances navigators -- that work collaboratively with our health care team to be able to provide additional supports to the health team, but also being able to provide additional support that is culturally relevant, right, and engaged in the community for the patients that we serve.

And we found that that improves engagement of the patient, retention and care, and helps the workforce be able to serve those populations when we work collaboratively. Absolutely.

*Mr. Ruiz. Thank you. I ran out of time, but I would like to follow up with you in picking your brain on specific policies that can help promote that model, which has been shown to be effective.

Thank you, and I yield back.

*Ms. DeGette. I thank the gentleman. The chair now recognized as Mr. Long for five minutes.

*Mr. Long. Thank you, Madam Chair.

And I was afraid my clothes were going to go out of

style during that five minutes, Mr. Ruiz. That was a long five minutes. I don't know what happened to our clock there, but I am ready to go now. So I would like to take a point of personal privilege for Chris Thomas.

Mr. Thomas, that opening of yours was one of the most heart-wrenching openings I have ever heard on this committee. And I know that my wife is on the suicide prevention board there, in Washington, D.C. And God bless you and your family. And anything we can do through this committee, anything that -- advocates like you speaking out really, really helps. And I just want you to know that I, from the bottom of my heart, truly, truly appreciate your opening remarks today.

I also want to thank Greg Walden, Diana DeGette, and Dr. Burgess. I hate to leave anyone out, but I know in the last Congress, Diana, Greg, and Dr. Burgess and others did yeoman's work on telehealth and getting that in place, getting it done before we really needed it, before the pandemic. And that was a great, great move on the committee's part.

And so Dr. Fortuna, with that being said, I would like to address my first question to you, and thank you for being here today.

Throughout the public health emergency, we have heard from patient groups and providers on how beneficial

telehealth has been for access. These telehealth flexibilities were extended to behavioral health services, but there were some limitations. Looking back on the changes that the aforementioned people made along with the committee, what worked and what did not work?

*Dr. Fortuna. Thank you very much for that question. Telehealth has been critical for us to maintain behavioral health access.

Before the changes that were made under the emergency for telehealth at the San Francisco General Hospital, for example, we could not see any patients through telehealth. It was not covered for our publicly-insured patients, or Medi-Cal, in California.

And when we instituted telehealth, which -- we had a lot of support from the APA, and from others who had evidence-based ways of doing telepsychiatry -- psychiatry has been doing this for a very long time -- we instituted from, you know, 0 to 100 in a week or two, and we actually were able to maintain, you know, access with our patients. About 90 percent of our patients were able to be able to be retained in mental health services.

There were a few things that helped that. One was sort of the relaxation to be able to actually use different modalities for being able to do video or audio. Audio, which we mentioned a few times during this hearing, was critical

for some of our patients who did not have access to the video components of telehealth. And it did make a difference. And I know many, many instances where people were talking to me about that it really prevented, potentially, a suicide or an overdose. And people actually reached out when they critically needed help. And I could access my patients, whether they were, you know, housed or homeless or had WiFi or no WiFi.

So we really want to maintain that, and also the fact that some people could not come in to the clinic. At different points, the fact that we could see them in telehealth without requiring an in-person evaluation, for example, actually increased our access, reduced our no-show rates tremendously, and gave us great flexibility to be able to serve our population.

So, you know, we would definitely want to see that, all of those sort of benefits of telehealth, to continue into the future, both --

*Mr. Long. Let me try to get in --

*Dr. Fortuna. -- if we are talking about hybrid and --

*Mr. Long. -- one other question here for you, Dr. Fortuna.

*Dr. Fortuna. All right.

*Mr. Long. There is a nationwide, as we know, mental health crisis, and it is being felt acutely all throughout my

district, which is mainly a rural area, through the rural areas, with shortages of mental health professionals. The majority of mental health professionals shortages -- the shortage areas are rural, as I said.

I know that the mental health workforce can participate in the Medicare graduate medical education program. But what are the other avenues we should be looking at to train and grow the workforce in the rural and under-served areas?

And you have 36 seconds.

*Dr. Fortuna. All right. Well, I mean, I think, definitely, if we could have more funding for medical graduate education in -- especially in the mental health fields, in psychiatry and allied fields -- mental health, psychology -- fellowships and loan repayment programs for people to work in these under-served areas, both rural and otherwise, where there is a lack of providers, and especially support for people who have sort of linguistic and cultural -- broadly, right -- sort of expertise to be able to come into communities. So funding that would be very helpful.

*Mr. Long. Okay. I don't have any time left, but if I did, I would yield it back. Thank you, Madam Chair.

*Ms. DeGette. Thank you so much, Mr. Long. I guess Mr. Tonko is still having some technical issues, so I will go to Mr. Peters.

Mr. Peters, you are recognized for five minutes.

*Mr. Peters. Thank you so much for this really important and fascinating hearing. I do know that data from 2020 shows that, while suicide deaths declined overall compared to 2019, death by suicide for children and young people increased, particularly among youth of color. I want to ask Dr. Fortuna.

Based on your research and clinical practice, do you have -- are there particular key factors that are driving these trends, particularly among youth of color?

*Dr. Fortuna. Yes. I think that it is -- again, it is multi-factorial, and research is really looking into -- getting to the bottom of this, but there is a few things.

One is I think that youth of color, especially ones living in disenfranchised communities, are experiencing escalating stress. It has been a long time. It was before the pandemic, right? And those relate to issues around poverty, discrimination, racism, inadequate supports in schools, and a lack of, I would say, timely and appropriate and quality mental health services early, when youth are first presenting with these symptoms of stress or distress.

It -- without the access of services, you know, what happens to begin as mental -- a more sort of anxious -- and the lower symptoms -- escalates into severe depression and illness and suicidality. So a lack of access to services and extreme stressors.

And in terms of pandemic-related, one of the things that I want to underline is that over 200,000 children have been orphaned through the pandemic, or have had a significant person near them pass away or die due to COVID, and that has been disproportionately impacting communities of color. So that is something that we are grappling with, on top of everything else.

*Mr. Peters. Can I ask Mr. Paley if The Trevor Project has identified any -- or adopted any new strategies in response to these trends as they affect LGBTQ young people?

*Mr. Paley. We see -- many of the same issues that Dr. Fortuna talked about related to people of color and youth of color apply to LGBTQ young people. And I think it is really important that we also recognize many LGBT --

*Mr. Peters. I don't want to cut you off. I need to know whether you have strategies that you -- another -- I only have some so much time. Have you adopted new strategies with respect to these new trends?

*Mr. Paley. Yes, we have been working to provide more support for young people, so that they can ensure that they can reach out and get support. That is through more resourcing on The Trevor Project services, as well as advocating for 988 to be fully funded for all Americans, as well as specialized services for LGBTQ young people, tribal communities, and other marginalized and at-risk groups.

*Mr. Peters. Thank you very much. I do want to highlight that Mr. Bilirakis and I introduced the Suicide and Threat Assessment Nationally Dedicated to Universal Protection -- Prevention, or STAND UP Act, which would encourage schools to implement evidence-based suicide prevention training for students.

Mr. Thomas, you mentioned in your testimony that your foundation is focused on working with adults. We interact with students in the school community. What role do you think teachers and coaches, in particular, can play in mental health awareness?

And why did you choose to focus the foundation's efforts on these community leaders?

*Mr. Thomas. Yes, thank you for the question. And our focus has been, actually, working with the teachers and coaches who have an influence and impact young people, particularly young people of color, and we believe the key strategies there are teaching them the importance of what we call the D Lines: don't ignore your gut; listen for the signs; interact; name the concern; evidence the concern; and support -- provide a supportive environment. So that is what we are doing right now, teaching these lessons in schools in Dallas and in Vegas, with the goal to go national.

*Mr. Peters. And do you think there is a role for something like the STAND UP Act which would support training,

best practices, and implementation of evidence-based suicide prevention programs in schools, get people to look out for these things on the ground, and, you know, sort of before you even get to the professionals? Do you think that resources like that would help build awareness and save lives?

*Mr. Thomas. I definitely believe evidence-based programing in schools that is sort of mandated, as well as funded, would definitely help the students -- in particular students of color, because, as said before, the lack of access to care, as well as all the other structural issues that exist for people of color, whether it is racism or micro-aggressions, plays a significant impact in their mental health.

*Mr. Peters. And I just want to highlight one of the things that you said is that almost all of these folks, these young people, give us a sign about --

*Mr. Thomas. Yes, sir.

*Mr. Peters. -- that they are considering this. And just the power of people in the public knowing what to look for can make a big difference in interventions.

*Mr. Thomas. Yes, sir.

*Mr. Peters. So I really appreciate your loss. I want to say I certainly -- I grieve for you.

And I want to thank all the witnesses for coming out and offering this wonderful testimony.

Thank you, Madam Chair, I yield back.

*Ms. DeGette. Thank you so much, Mr. Peters. The chair now recognizes Mr. Palmer for five minutes.

*Mr. Palmer. Thank you. Thank you, Madam Chairman, and I want to thank the witnesses and the ranking member for holding this hearing. It is very important. I have had several of our members raise these questions about the suicide rate among young people. I think it was an all-time high for people under 24.

And back in July of 2020, former CDC director, Robert Redfield, noticed that there was a mental health crisis among young people, and argued that the lockdowns were disproportionately affecting that age demographic. The CDC reported that there was a 51 percent higher rate of suicide attempts, compared to the same timeframe in 2019. And I just want to know if anyone on the panel has made any attempt to study the impact of the school lockdowns and the link to the unprecedented rise in suicides among school children.

And also, I also think the unprecedented increase in the number of overdose deaths, drug overdose deaths -- I may be off base here a little bit, but I think, in some of those cases, some of these drug overdose deaths were tantamount to a suicide.

I would just like to get some comment, and maybe start with Dr. McCance-Katz, please.

*Dr. McCance-Katz. Well, I certainly follow the literature, and I am quite concerned about these issues. It is my belief that probably a fair number of opioid overdose deaths and drug overdose deaths at large are suicides, and they are just suicides that we haven't been able to identify as such.

When people are isolated and lack the supports that they need, and our health care system at the time you were speaking of was basically not available, it is not surprising that people had more access to drugs and alcohol, and sought relief from what they were experiencing.

*Mr. Palmer. I can't see the time clock. I am in my vehicle. So I am going to go ahead and move --

*Ms. DeGette. You are at about -- sir, you are about 2 minutes and 40 seconds.

*Mr. Palmer. Okay, thank you, Madam Chairman. I want to go ahead and move to something else, and it is better than suicide, and I am surprised no one has mentioned that in this hearing.

According to the U.S. Department of Veterans Affairs, their 2021 National Veterans Suicide Prevention Annual Report showed that the overall veteran suicide rate had decreased in 2019 from 2018 to 2017. But when we hit the middle of the lockdowns, it started back up. From April to June it was up 11.3 percent. In the third quarter it was up 22 percent.

And then, in the fourth quarter of 2020, it was up a shocking 25 percent.

And Dr. McCance-Katz, have you looked at that? Have we looked at the impact of the lockdowns on veteran suicides?

*Dr. McCance-Katz. What -- yes. What I can say is that there have been a number of different types of programs that have been put in place to support veterans, and these are programs that include pairing veterans with other veterans. They include the ability for veterans who are experiencing these kinds of serious mental health effects to be with other veterans, and to get the supports that they need. And during the course of the pandemic, these programs were not available because of the mitigation responses to COVID-19. And so, again, it is just a very unfortunate reality that we live with, that this affected veterans in this way.

*Mr. Palmer. Thank you.

I know I have got very little time left, but Madam Chairman, at some point I think we also need to expand this, and talk about the mental health aspect related to homelessness, and what we need to be doing there. And it is also a problem for veterans. There are a number of veterans with mental health issues who are also homeless.

And I imagine my time is almost up, so I will yield back.

*Ms. DeGette. Okay. Yes, your time is almost up, Mr.

-- I was just informed by staff that members are supposed to have their cameras on under the House rules in these hearings. But I thought that --

*Mr. Palmer. I have it on, don't I?

*Ms. DeGette. No, it is --

*Mr. Palmer. Yes, I think I --

*Ms. DeGette. First of all, my name is Diana.

But second of all, you are not -- it is not coming on the screen. But that is okay. We will --

*Mr. Palmer. All right.

*Ms. DeGette. We will -- I thought your questions went great, and we will now go to our next questioner, who is going to be -- I don't know if Mr. Tonko's -- I don't know if Mr. Tonko's technological issues have been resolved. I don't see him, so I am going to go to Ms. Schrier.

*Ms. Schrier. Well, thank you, Madam -- and thank you to our excellent witnesses today for this discussion.

As the only pediatrician in Congress, I am particularly concerned about the mental health --

[Audio malfunction.]

*Ms. Schrier. -- nation's children. The public health response to this pandemic initially curtailed our in-person interactions with friends, and with family, and, boy, for tweens and teens, whose healthy development really hinges on these relationships with peers at that age, most have turned

to online interactions with their friends, and social media, in that sense, has really helped maintain friends and limit feelings of isolation.

But social media is also a rabbit hole that can lead to exposure to harmful content, and really hurt children. And the algorithms used by platforms like Facebook make it even more likely that a simple online search might lead children deeper and deeper into exposure to dangerous content. For example, a girl who looks for information about healthy eating could quickly be exposed to content that leads to eating disorders.

And this is even more dangerous at a time of uncertainty, when people are just looking for a little bit of control in their lives. Children feeling sad, as we heard, might find themselves channeled to discussions that glorify suicide or --

[Audio malfunction.]

*Ms. Schrier. And boys are often targeted by hate groups. Yesterday I spoke with a psychologist at my son's school, who shared these concerns and noted that she is seeing markedly increased levels of acuity with depression, anxiety, and eating disorders. But she is also seeing them in younger children. And she echoed concerns about social media. And it was interesting, because she said many children wish that their parents would monitor their use more

because sometimes they see such shocking things online that they are embarrassed -- that they don't even know how to ask their parents about it.

So, Dr. Nesi, I know you have done so much research in this area, and I was wondering if you could talk more about the role that parents, therapists, pediatricians, and schools can play in helping teens kind of manage their social media use, and navigate this brave new world, and help them be more thoughtful about how and when they use it.

*Dr. Nesi. Yes, thanks for this question. I know that a lot of parents are -- and schools are concerned about social media and how they can protect their kids' mental health.

I think let's maybe focus on parents for a minute. I think for -- what is going to work for each family is going to be a bit different. But there are some key principles, I think, supported by research that parents can keep in mind.

So I think emphasizing open communication with teens about social media, engaging them in the process of learning what is working for them and not working for them is critical.

Setting reasonable limits and expectations. So parents might consider setting limits by times of day, location that their kids can use their phones, or maybe limiting certain content or activities in order to reduce exposure to harmful

content.

I also think protecting sleep is critical. The evidence is pretty clear that nighttime device use can get in the way of sleep, and so parents need to help their teens ensure that they are getting adequate sleep.

And then finally, I think parents need to be aware of signs that their teen is really struggling. So if they are not themselves, you know, there is -- using technology in a way that seems excessive, or is really interfering with their well-being, then they may need to get professional help, and seek out therapy services for their teen.

*Ms. Schrier. Thank you. And now we just have to coach parents -- how to do some of those things that require some technical expertise themselves.

I just have a minute left. So Dr. Fortuna, the psychologist at my son's school also noted that she is really overstretched. She works for a hospital. They have a school levy that pays for them. Now they only have two for the whole district, and that we need more psychologists, but there just isn't a pipeline. There just aren't enough people to go around in the private or school realm.

I was wondering if you have any ideas about how to leverage her expertise -- you know, groups, or training others to do some of that work. How can we be creative about using that limited resource?

*Dr. Fortuna. Yes, I mean, I think it -- thank you for that -- I mean, I think it goes a little bit to what we were just talking a little bit before, with -- about the workforce expansion and diversification of that, right?

So beyond trying to get more people into the workforce through different incentives, I think we can use para-professionals, you know, community health workers, even in the school, peer partners, peer, you know, family partners, who can work with families and young people.

I mean, we have actually tried a project which really trained peers to be able to be a supportive group for special populations like LGBTQ youth or otherwise.

And to have training. I think what we are finding in psychology and psychiatry is we can do a lot with training people in aspects of our expertise, so that we can work in a very collaborative model, and not just rely on people at higher -- with higher degrees of the profession.

*Ms. Schrier. Thank you. She noted that, too, that helping kids know how to handle it when a friend comes to them is really important. Thank you.

I yield back.

*Ms. DeGette. Thank you so much.

Mr. Joyce, you are now recognized for five minutes.

*Mr. Joyce. Thank you for yielding, Chair DeGette, and for convening such an important hearing.

According to the results from the 2020 National Survey on Drug Use and Health, almost eight million adults in and around rural areas reported having any mental illness. In addition, almost two million adults in these areas reported having serious thoughts about suicide during that year.

While the prevalence of mental illness is similar between rural and urban residents, the services can be very different. Mental health care needs are often not met in many rural communities across our country, because adequate services are not available. This is particularly acute in pediatric populations. And I would like to thank Chair Eshoo for the work that we have been doing to address this matter together.

My questions are first for Dr. McCance-Katz.

Dr. McCance-Katz, what factors are unique to rural communities that challenge mental health care delivery?

*Dr. McCance-Katz. Well, one of the huge challenges is just distance. You are quite right that the services tend to be limited. But there is great distances for people to travel, which is why telehealth and hybrid versions of telehealth are, I think, in my view, are so important to continue.

*Mr. Joyce. Are there additional steps besides telehealth, which I, as a physician, find to be incredibly important? Are there additional steps that we can take,

particularly while trying to address pediatric health care and the shortfall of providers in rural communities?

*Dr. McCance-Katz. Well, one of the areas that still awaits major expansion, but which I think is very promising for rural areas, is mobile health. And this is a resource that is being developed in some states. It is a resource that, at SAMHSA, we encouraged use of, in collaboration, actually, with the Department of Agriculture.

And we think that -- I think that this is a way to help people to get services who would otherwise not have any chance at all of getting face-to-face services. And when that can be also supplemented by telehealth services, including use of telephone, because rural areas really are at a deficit in terms of their access to broadband, those -- that combination will help people to get the care and treatment they need.

We also need to expand services in our schools, so that rural-based children and their families can get those services easily.

*Mr. Joyce. I think the all-of-the-above approach that you directed -- expanding mobile health, telehealth, telephone health, I think that those are all important options that we need to continue to evaluate.

And just yesterday we had a similar hearing regarding rural broadband, but I want to talk about coordination. If

we want to be better in coordination with primary care doctors and with mental health providers, what is the best avenue to explore and to do that?

*Dr. McCance-Katz. Is it a question for me?

*Mr. Joyce. Yes.

*Dr. McCance-Katz. Yes. So I think the model exists. And again, I said it earlier, but I will say it again because I think this is the way of the future, and that is the integrated health care for those with serious mental illnesses that expands to all age groups: elders, adults, and children and adolescents. Integrated services in the form of certified community behavioral health clinics that also offer 24/7 crisis intervention services, mobile services, and bricks and mortar, so that an individual doesn't have to go to an ED, but can go to a service that is -- has individuals there that are trained to meet their needs.

*Mr. Joyce. In rural communities that are often -- as we have mentioned throughout this hearing, there are not the resources to provide psychiatric -- pediatric psychiatric care. And so primary care doctors actually shoulder a majority of the psychiatric care, because they are the only resource that is available.

Do you feel that additional training in psychiatric and psychological care should be instituted and occur in primary

care programs?

*Dr. McCance-Katz. I think that would be immensely helpful. We know that the seriously mentally ill are the population that are more likely to be seen by behavioral health and psychiatrists. But the majority of mild to moderate mental illness is going to be seen by primary care, and they don't get a substantial amount of training to meet those needs, so it can be overwhelming for them.

SAMHSA has programs to help with that training. HRSA also has the ability to provide those kinds of resources. And I think that Congress looking at that and expanding those resources, I think, would be very, very helpful to millions of Americans in need.

*Mr. Joyce. Thank you. I share those concerns, and those millions of Americans will need that care.

Thank you, Chair DeGette, and I yield my remaining time.

*Ms. DeGette. Thank you so much.

I want to thank Mr. Tonko for his perseverance. I understand that he is in a better place now, and I will recognize him for five minutes.

*Mr. Tonko. Okay, thank you, Madam Chair. I hope so. Can you hear me?

[No response.]

*Mr. Tonko. Okay. Mr. Thomas, again, you have been working to engage communities in awareness about mental

health for several years, two of them under the cloud of this pandemic. What COVID-19-related mental health challenges have come up in your conversations?

*Mr. Thomas. Oh, thank you for that question, Mr. Tonko. And our organization has been in existence for about a year now, starting in May of 2021. But I have also been working on the American Foundation for Suicide Prevention boards.

And the things we have noticed is a lack of connection as relates to COVID-19. We have seen an increase in the realization of the issues of institutional and micro-aggressions of racism among our organizations, our communities, and that creating a divide amongst ourselves. And then, the lack of access of care is sort of what we have noticed, as well, as a result of COVID-19.

But the other thing we have noticed, from a positive standpoint, has been the opening up and normalization of conversations amongst influencers about mental health and suicide prevention. Whether it is, you know, Kevin Love or Simone Biles, my own son Solomon talking about the importance of mental wellness and suicide prevention, we have seen an uptick in that kind of conversation for folks to understand that it is okay to not be okay, and to start talking about the importance of whole health.

*Mr. Tonko. Well, thank you. These kind of examples

led me to introduce H.R. 1716, the COVID-19 Mental Health Research Act, with Congressman Katko. This bipartisan legislation would fund research to study the effects of COVID-19, the pandemic, and what it has had on mental health of Americans, including its impact on children and health care providers.

Dr. Fortuna, as a researcher, do you think it is important to research the pandemic's impact on Americans' mental health?

And how might such research help us better understand how to meet the Americans' mental health needs?

*Dr. Fortuna. Yes, I mean, absolutely. I think it is critical that we study the mental health impacts.

I mean, like all disasters and crises, this pandemic, it has the -- first, health issues that it has an impact on. But then the wave, the tsunami that we call it often in our field, of the mental health impact of such crises.

And it is multi-factorial, right? So that is why I think it is really important to have research, because we can understand what are the different elements that are impacting across the lifespan, and we can also really -- and definitely need to study interventions.

The way that we can come out of this pandemic is to be ready with understanding how do we prepare for future crises. Because I think that is something that we can learn, as well.

And how do -- we can have the agility to be able to respond to the mental health needs of America through the different kinds of resources, telehealth, you know, integrated services. You know, how do we have to get those things to the evidence base, so that we can be able to serve Americans throughout this crisis and the next one, right?

*Mr. Tonko. Thank you. Thank you. And just to briefly confirm, Doctor, the pandemic's impact on children's mental health, I would think, is multi-faceted and, despite claims this morning, is not due to a single factor, like children wearing masks. Would you agree with that?

*Dr. Fortuna. I would definitely agree that it is multiple factors.

You know, no one liked being, you know, social distancing, but there were so many other things, like in the story that I opened up with, in terms of, you know, loss. People were really sort of grappling with already pre-existing mental health needs, economic devastation in dis-enfranchised communities. It just -- it is just very multi-factorial, and we have to look at it comprehensively.

*Mr. Tonko. Right. Well, I thought it was important to put that on to the record.

It is important that we base our decisions on sound data, and those data are extremely important, and not just on conjecture.

Mr. Paley, your testimony discussed some of the pandemic's harmful impacts on LGBTQ1+ [sic] young people. Do you believe these impacts are indicative of similar effects on young people, and particularly youth of color, as well?

*Mr. Paley. Yes. The pandemic has had -- exacerbated a lot of the inequality inequities that we saw in access to mental health care before the pandemic. So it has had very profound impacts on LGBTQ people, youth of color, tribal communities, veterans.

And I think it is really important that we recognize that many people occupy multiple identities. We have many people who are LGBTQ youth of color, and veterans of color, and LGBTQ veterans, and that it -- that is why it is so important we recognize that mental health care is not one size fits all, and we need to make sure that we are providing care that is culturally competent, and that is appropriate for every type of person, regardless of what -- depending on what their needs are.

*Mr. Tonko. Well, thank you to all of our witnesses for helping us better focus on the mental health needs of Americans through this trying time.

And Madam Chair, thank you for your flexibility. I yield back.

*Ms. DeGette. Thank you so much. The chair now recognizes Mrs. Trahan for five minutes.

*Mrs. Trahan. Thank you, Madam Chair.

On December 19th, 2021, the New York Times published a story titled, "Where the Despairing Log On and Learn Ways to Die.'' Since then, my office has been conducting an investigation, alongside Representative McKinley and others, on online suicide instruction forums. In this work I have heard heartbreaking stories from parents.

Mr. Thomas, thank you for sharing your daughter's story with us today. Mary-Ellen Viglis, a Virginia resident, gave me permission to share her son's story, as well.

And Mary-Ellen describes her son, Demetrios James, as an incredibly loving individual. But like so many young people, he struggled with depression and anxiety in his early teen years. Demetrios James first attempted to die by suicide when he was just 14 years old. And after the attempt, I understand it took a year to get off a wait list to see a psychiatrist. Public schools in the area did not offer mental health services, so his mom put him in a special school with regular access to peer recovery counselors, where he thrived for a period of time.

Throughout his late teens, however, he continued to struggle with combinations of depression and substance abuse. At 19 he was doing better. He had a job, and he had a community of older young people in recovery that he met with regularly. When the pandemic hit, he lost his job, and his

meetings were canceled. The isolation became too much.

He discovered a website that encouraged suicide, and provided information and access to methods. There he learned about a poison popularized by the website, and where he could buy it, which he did, with ease, on Amazon. Not long after the package arrived, he died by suicide.

What makes this story so powerful is that it speaks directly to the multi-faceted set of issues that all of my colleagues have raised today: a shortage of psychiatrists, the importance of funding for school mental health programs, the existence of online forums that lack accountability for their safety of their products.

One element of Demetrios James's story that is uniquely troubling is the method he used, a poison described in a recent court case as a substance that "turns a living person into jerky.'' Amazon not only sells this poison using expedited shipping, but once a user searches for the product it may be recommended to them, along with an ad for an instruction manual and an acid reduction medicine that makes the poison easier to take.

Dr. Nesi, can you speak to why ease of access, in general, to death-by-suicide methods are so problematic, once an individual is experiencing suicide ideation?

*Dr. Nesi. Thank you for sharing that story, and for this question.

Yes, I -- so I think we know that easy access to means is a key risk factor for suicide among youth and adults. That is why one of the main methods that we have for reducing suicide risk is limiting access to means. And that is something that we do with patients, as psychologists and psychiatrists. So clearly, it is an issue to have easy access to that kind of thing, whether that comes in person or if it comes online.

*Mrs. Trahan. And similarly, Dr. Nesi, what does the research tell us about the impact of online content related to death-by-suicide methods on young people who may be struggling with mental health?

*Dr. Nesi. Yes, this is a really important question, and I think that there is -- you know, so when it comes to suicide-related content, I think that there is a lot of different types of content out there. And some of it can be helpful. For example, when it provides support, when it offers opportunities for intervention when kids are in crisis, or when it provides them information on resources like the crisis text line or information from AFSP.

But obviously, there are cases where it can be really problematic, and that includes as we discuss cases where content might glamorize or even encourage suicide cases, where methods are described in detail. We know that that can have a harmful effect on both young people and adults.

*Mrs. Trahan. Well, I want to thank you all for all the important work. As a mother, I am particularly grateful to the parents who have shared their stories, and who work tirelessly to improve mental health care in this country.

And if any of my colleagues are as horrified as I am that online forums that encourage suicide exist, and want to hold them accountable for the deaths that they cause, let me know.

Thank you, I yield back.

*Ms. DeGette. I thank the gentlelady. Mr. O'Halleran, you are now recognized for five minutes.

*Mr. O'Halleran. Thank you, Madam Chair. I appreciate that.

I -- this has been a very sad day to hear all that is going on in this particular issue. Caring for mental health and -- for Americans is essential, and the need has become even more pronounced during the pandemic. We know that different populations have particular needs. In particular, children are in dire need of mental health support, particularly Native Americans, and rural Americans, and other under-served communities that often lack and do, in fact, lack adequate mental health resources.

Importantly, we know that our children are susceptible to mental health challenges posed by an increased reliance on social media. And many of our children are only just

recovering from spending much of the last two years away from classrooms, having to engage in remote learning with limited, in-person interaction.

I -- in a past life I was a Chicago police homicide detective. I have seen way too much attempted suicide and suicide. I have seen the impacts that it has had on communities, but most importantly on families, families that are addressing mental health and still struggling, families that do not have the help needed, families that have lost a loved one, and the trauma that that brings to that family year after year after year.

We have to do better. We have to find a way to address this in a way that is -- it recognizes what it does to our society, what -- the impacts from our society, and -- has done to our children and adults and, again, families.

We spend a lot of money on social services. It hasn't gotten us to where we need to be. We -- prior to the pandemic we did not have the workforce available. And now, earlier on, we talked about workforce development. They are on overload. They are overwhelmed, and they were overwhelmed prior to this. I see, day in and day out, the fact that we cannot find the people that want to get back into it, and did not want to get into it, even beforehand.

So there is -- disparities between communities is tremendous. Therapies alone, just throwing money at

therapies, is just not enough. We need telecommunications, obviously, and telemedicine. We need people out in the field. We are losing our practitioners and providers just at terrible rates. And this is a dire time.

So with that doctor, Dr. Fortuna, thank you for your testimony. What are some of the disparities you are seeing among children, and what factors do you believe lead -- or what is driving them to these specific mental health challenges?

*Dr. Fortuna. Right. I mean, when we are talking about disparities, you know, we really have to think about -- the way I think about the way out of, you know, this problem and toward solution is how can we work across our systems of care, right?

We have talked about schools, right, and teachers being completely overwhelmed, and having to deal with mental health, primary care providers having to take the big bulk of addressing mental health services, and there being very few child psychiatry and psychology-trained workforce people, right? There is only between 8,000 to 9,000 child psychiatrists in the country for millions of children who need mental health.

And the way that we can do that is how do we expand those resources through multiple factors.

You know, one is the one that we have been talking

about, is telehealth. But telehealth allows not only for one-to-one services, but can also provide consultation and expanding services to schools and primary care. So I think that that is one thing. That is another way of looking at primary -- at telehealth as important, not just sort of one-to-one care, but to actually provide consultation to schools and to primary care providers.

Integrated primary care services, where pediatricians are seeing patients very early, from infancy onward, and can pick up mental health and developmental health needs. You know, the APA is really supporting an issue of integrated care and a collaborative care model, which allows psychiatrists to work with primary care providers and care managers in providing comprehensive care that is evidence-based, and has over 90 studies showing that that can be very effective in taking a really sort of, you know, outcomes-focused approach to that, and also population health, where you can work with panels of young people. It can do that for adult and child services, and integrating, you know, really good mental health services within schools.

So those are the -- you know, primary care in schools are places where kids are. So --

*Mr. O'Halleran. Doctor, I have to say thank you, and my time is up.

And I hope we have learned, from this last two years and

the many decades beforehand, that this issue must be resolved in order to make sure our families can have a quality of life throughout America that is conducive to the way of life we expect to have.

Thank you very much.

*Ms. DeGette. Thank you so much. Thanks, Mr. O'Halleran. We -- now we will turn to our members who are waiving on.

Welcome. We are glad to have you. And we are going to start with Mr. Latta.

Mr. Latta, you are recognized for five minutes.

*Mr. Latta. Well, thank you very much. First I would like to thank the chair for allowing me to waive on today, and also for holding this very important hearing. And also, thanks for our witnesses today, for your testimony.

As we continue to navigate coronavirus and work to return to normalcy, we must address one important aspect of life that has been severely impacted since COVID lockdowns were first implemented, and that is mental health.

And as we have heard today, with social isolation the continuous fear of an invisible enemy and the loss of familiar, everyday routines compounded the challenges our nation was facing prior to the onset of the pandemic. And we are also seeing the tragic consequences because of it.

Substance use disorder is one of the greatest challenges

to accompany the mental health crisis. And it is no coincidence that the United States had a record number of overdoses last year of 101,263 over a 12-month period during the peak of the public health emergency. We saw more people suffering depression and anxiety turn to outlets that they thought would help them with their struggles. We also saw suicide rise to be the second-leading cause of death among people between the ages of 10 and 34.

Americans who are experiencing crisis need help, and I am proud to have worked on bipartisan legislation to designate 988 as the National Hotline -- Suicide Hotline. In addition, I have introduced several pieces of legislation that provide immediate assistance to those who are suffering, such as the CRISIS Act, which would allow for better access to crisis call centers and outreach, and treat -- the TREAT Act, which would remove barriers to telehealth services such as mental health care across state lines.

Dr. McCance-Katz, if I could begin with you, during your time leading SAMHSA, what roadblocks did you witness that resulted in patients not receiving care?

*Dr. McCance-Katz. Some of -- there were a number of ways that patients experienced roadblocks. There was an overall lack of access to care.

We lack the behavioral health providers that we need. It has been mentioned a number of times, but I think it is

worth reiterating just what kind of severe shortage we had prior to the pandemic, and it has only worsened with the loss of behavioral health providers and other health care providers from the field.

Low payments, low reimbursements for providers also are a disincentive for people to enter the field and, in some cases, make it impossible for some facilities to continue offering services.

And we have really what continues to be a disjointed service system, where it is very difficult for providers to share information. Congress has made some legislative changes that will help with that. I personally think that should be followed to make sure that that is happening.

And I think the kinds of legislation that you are talking about are exactly the kinds of legislation that will be helpful in moving our system forward and meeting the needs of the great number of Americans with these issues.

*Mr. Latta. Let me add -- continue another question with you on this, because, again, as I mentioned in my remarks, I introduced the CRISIS Act, which would direct states to utilize funds for the Mental Health Block Grant for call centers 24/7, mobile crisis services, and better programs offering care.

Do you believe that services like this could help improve the situation, and help save lives?

*Dr. McCance-Katz. I do, particularly the provision of crisis services. We know that crisis services provided by behavioral health providers are really key to keeping people out of the hospital, to providing them the kinds of outpatient supports that would allow them to continue in the community, and get into recovery with the appropriate support. So those crisis services are really critical.

*Mr. Latta. You know, to follow up on a point that you made, you had said about the ability to share information, you said that we have -- we are doing better at it. But what should be done, maybe in your opinion, to make it even better?

*Dr. McCance-Katz. So I -- it is my own view, and I am an addiction specialist -- so I can tell you that the 42 CFR part 2 is a big barrier to sharing information and getting people to the kind of care and treatment that they need when they have co-occurring disorders. Congress has directed that 42 CFR part 2 be subsumed under HIPAA. I think that was the right move.

And having said that, I have not heard to this point where that is at, so I hope that that will move along. I do think that that will improve service delivery.

*Mr. Latta. Well, thank you very much.

And again, Madam Chair, I appreciate the ability to waive on to the subcommittee today. Thank you very much.

*Ms. DeGette. You bet.

Doctor, that was the issue that Mr. Murphy and I worked on together when he was the chair of this subcommittee. And the effort continues.

I am now very pleased to recognize Mr. Cardenas for five minutes.

*Mr. Cardenas. Thank you very much, Madam Chairwoman and also Ranking Member Griffith, for holding this very critical and important hearing. And I know we have had other hearings in the past, but it couldn't be more timely than it is today. So thank you so much for your leadership.

And also, I want to thank the committee staff and also the witnesses for providing these important statistics and information regarding the disproportionate impacts on Native American communities, Black communities, LGBTQ communities, and others. It is unfortunate that a community that is negatively impacted at a greater rate, if not equal rate, is the American Latinos. So I would like to suggest and hope that the witnesses and the committee staff please include the statistics on the impacts of the Latino community in their statements and reports from this day, and also going forward.

So also, I have -- my first question is to Mr. Paley.

Mr. Paley, I want to thank you for The Trevor Project's dedication to serving our young people, and for calling attention to the urgent need to make sure 988 is ready when

the number is activated in July. I share your concerns, and will be leading a bipartisan 988 and crisis services task force for the Congressional Mental Health Caucus to address these issues.

In the next few weeks I will be introducing bipartisan legislation to support 988 implementation. One of its provisions increases funding for 988 operations and call centers throughout the country. As calls to the 988 hotline are expected to be very, very high immediately, the increased funding is needed to ensure that a timely 24/7 response is available, so people aren't left waiting or on hold during a mental health emergency.

Importantly, it is also -- allocates resources for specialized services for LGBTQ individuals, people of color, people who speak a language other than English, people who are deaf or hard of hearing, and other populations that have not been served well with a one-size-fits-all approach.

Mr. Paley, can you comment on why a timely response and specialized services are important, especially for marginalized communities and under-served populations, including rural communities, as well?

*Mr. Paley. The need is critical, because different people have different needs, as we said before. There isn't a one-size-fits-all solution. That is why we had a veterans line. We need solutions for veterans. We need solutions for

people of color, for LGBTQ young people, and for people of many different identities.

I am very grateful for your leadership on these issues, and I -- we agree with you that we need to fully fund the lifeline, and particularly the -- appreciate your attention to specialized services for at-risk groups, including LGBTQ young people.

And I think it is important that we call out that we need more funding, and we need to make sure that the planning is happening appropriately, so that when we launch 988 -- and many people are going to be aware of it and reaching out -- that we have the services needed to help them. That includes the overall infrastructure for all Americans, and including infrastructure for specialized services in communities like LGBTQ young people.

So there is a lot more that needs to be done to make sure --

*Mr. Cardenas. Thank you.

*Mr. Paley. -- we are taking care of everyone.

*Mr. Cardenas. Thank you very much, Dr. Fortuna, and thank you so much for all the work you do for our young people. On the topic of 988 and crisis response, could you briefly comment on the importance of the crisis continuum of care, and if further investments in crisis care would benefit youth and their families who currently wait in an emergency

room for days, or sometimes don't even get the true access to care?

*Dr. Fortuna. Yes, absolutely. I mean, I just want to underline what has been said so far is that, you know, we really do have to have sort of this diversity of resources for people to be able to access -- and that continuum of care. And I would say that that is not only inpatient services, which are at a complete deficit for child and adolescent population, but with that we have to have the full continuum of care, including crisis. In some states they have even instituted what we call sort of urgent care in crisis, where you can immediately access services.

So all of those things are critical.

*Mr. Cardenas. Thank you. I have a follow-up question to that, and thank you for earlier pointing out some of the various factors that contribute to that lack of care.

The U.S. Department of Labor, Department of Health and Human Services, and Department of Treasury issued a joint report which found -- and I quote -- "Health plans and health insurance issuers are failing to deliver parity for mental health and substance use disorder benefits to those they cover.'' The Affordable Care Act has required it by law that there be parity for health services, as well as physical health.

How does this inadequate coverage play out in the clinic

or the hospital, and how does it impact patients, especially our children and teenagers?

*Dr. Fortuna. When there is a lack of parity, obviously, people lose access to behavioral health services, right?

I mean, I had mentioned earlier how, you know, even in inpatient services, we can -- you know, we can constantly get rejections because, you know, they do not want to further cover a stay, because it was not doing well enough or good enough.

And it is across the, you know, public-insured and insured -- privately-insured patients that we have found that cannot access services because it is not covered, and people cannot afford to reach mental health services in a timely fashion. So it is critical.

*Mr. Cardenas. Thank you.

I am sorry, I went over my time, Madam Chairwoman. And thank you so much for allowing me to waive on. I yield back.

*Ms. DeGette. Thank you for your questions. The chair is now very pleased to recognize Mr. Armstrong for five minutes.

*Mr. Armstrong. Thank you, Madam Chair, and thank you for letting me waive on, as well.

Over the past two years I have consistently heard from both providers and patients in North Dakota about how they

benefit from expanded access to telehealth. This was important prior to the pandemic in rural states, but obviously, has been escalated over the last several years.

A report published in December of 2021 by the U.S. Department of Health and Human Services found that the share of Medicare telehealth visits increased 63-fold in 2020. The report also found that one-third of behavioral health specialist visits were completely by telehealth. This is a figure that I am not surprised by, as I continue to hear from patients who are more comfortable with virtual visits for mental health over in-person evaluation.

These constituents face everyday barriers to mental health care access, such as limited providers in rural areas, unpredictable North Dakota winters preventing travel, and just overall small community stigma. However, now they are no longer putting off care. As expected, telehealth has -- as expanded telehealth has afforded this increased participation in mental health services.

During -- the COVID-19 pandemic resulted in a rapid transition across our state. My state reacted quickly, and in the early months of the pandemic, March and April 2020, saw the number of health providers at behavioral health clinics using telehealth grow from 71 to over 350 providers.

The Consolidated Appropriations Act of 2021 permanently expanded access to telehealth for mental health services. I

am proud this legislation will allow Medicare beneficiaries to receive telehealth services for mental health from the comfort and privacy of their home. However, when the public health emergency ends, the patients will need an in-person exam with a provider within six months before the initial telehealth encounter. This is a huge hurdle in rural America.

Dr. McCance-Katz, should we continue to utilize telehealth for mental health treatment, once the pandemic is over?

And I am assuming the answer is yes. And if so, do you see this in-person evaluation as a barrier to care, or is it an important function for ensuring the patient receives the personalized care they need?

*Dr. McCance-Katz. Yes, so I believe that patients do need to be seen by their clinician. I think that we need to provide flexibility, so that the kinds of problems that you are talking about don't occur.

So for example, I wouldn't say that a person needs to be seen in person before they can have a telehealth visit. I think that there are certain guardrails that we do have to have to reduce the likelihood of fraud, because that is an issue we have to consider with this kind of modality.

But having said that, it is an essential modality, and particularly for rural areas. This is going to be, I think,

lifesaving for people with mental health issues.

*Mr. Armstrong. Well, and for those that don't know, and most of you probably wouldn't, my grandmother was the head of the North Dakota Mental Health Association in North Dakota for 20 years during the farm crisis, and all of those issues. So I agree with that.

And I also think it is really important to recognize that, you know, if you have to delay an ACL surgery by three weeks or a month, it is different. If you are actually in mental health crisis, waiting three weeks to get in to see somebody is just an unacceptable outcome.

But given the rapid transition from in-person treatment to telehealth that I talked about earlier, do providers need specific training on how to use audio and video approaches for mental health treatment, or is it a relatively seamless transition for most providers?

*Dr. McCance-Katz. Well, thank you for that question, because I think it is really a very important conversation that we need to have with providers.

You do -- I think you do need training to do this in a way that protects patients' rights, that protects their privacy. It is important to train providers on how to engage their patient in a technology-based kind of interaction, how to judge what is going on in the environment where the patient is, what needs to be going on in your own environment

to make sure that you are giving the patient the attention and care that they need in a way that is going to be, again, protective of their needs and their rights to privacy. So I do believe that training on telehealth is necessary.

*Mr. Armstrong. And then I guess my last question is unique, and I would really -- not unique, but, I mean, every state in the country has done a very good job of building white picket fences around their own licensure apparatuses. Some are better than others, some are worse than others.

But how -- as we do this, what can the Federal Government to do to work to what I call -- to avoid paralysis by licensure? Because we are asking people to do this from other states in North Dakota, not just from larger communities.

That is 12 seconds left to answer. That is unfair, but give it a go.

*Dr. McCance-Katz. Well, I would simply say that Congress can expand, through legislation, the ability of providers in distant states to provide telehealth in other states.

*Mr. Armstrong. Thank you very much. I yield back. Thanks for allowing me to waive on.

*Ms. DeGette. Thank you so much.

And now, thank you for your patience. Congresswoman Blunt Rochester is recognized for five minutes.

*Ms. Blunt Rochester. Thank you so much, Madam Chair, also for the recognition and allowing me to waive on, and thank you so much to our witnesses for sharing your testimony today.

The COVID-19 pandemic, along with the upcoming implementation of 988 as a universal number for mental health crises and suicide prevention, have forced us to rethink how we approach mental health in our country. From the places people seek support and treatment, how we finance mental health services and hold insurers accountable for mental health coverage, to focusing on the unique needs of special populations like children, this hearing is pivotal.

Children and adolescents are not just little adults or, as Mr. Paley said, it is not a one size fits all. And unfortunately, investments in existing mental health programs do not always meaningfully reach the organizations and providers serving them. That is why I have been laser focused on advancing legislation tailored to meeting the unique needs of children and youth like our bipartisan TIKES Act, which is a telehealth for children bill that is led by myself and Representative Burgess. Also, our bipartisan Children's Mental Health Infrastructure Act.

My first question is for you, Mr. Thomas. First I want to just thank you so much for sharing your story, and also removing the stigma of mental health. We deeply appreciate

the work that you are doing and that your family is doing.

Trusted community-based organizations and schools are critical access points for children needing behavioral health intervention. And further, children remain more stable when they are connected to resources that provide ongoing behavioral health support. My legislation, Helping Kids Cope Act, H.R. 4944, would provide flexible funding to support a wide range of activities, including collaborations between community-based organizations, health care providers, and schools.

But I know it is often difficult for community-based organizations to find and coordinate with health care providers. Can you speak to your experience connecting youth to providers, and outline any suggestions on how these collaborations could be made easier?

*Mr. Thomas. Thank you for your question, and it is a very great question, and I look forward to hearing more about your Act.

I do think it is critical that we do connect and work with communities that are providing services to children, in particular children who are trying to focus on mental health.

In our experience with the Defensive Line, we have been able to work with key organizations like American Foundation for Suicide Prevention, Mental Health America to provide evidence-based training and programs to the schools, the

parents, the coaches, and the teachers to understand the warning signs.

So we have found it to be a very effective way to work together to collaborate, whether it is with the national organization, like I just mentioned, or even local ones like the Defensive Line's work with Faith, Fight, Finish, Dak Prescott's organization, to provide mental health, suicide prevention training.

We are finding it came at the right time, because of the focus amongst influencers, whether it is Dak, whether it is Solomon, whether it is other people like Lady Gaga, who are talking about mental health. So we have been able to leverage that synergy, that energy, and momentum to get into schools, to teach the -- to provide the training. So it is possible, and we are finding it -- that it is growing and becoming easier.

*Ms. Blunt Rochester. Thank you. Thank you.

And Dr. Fortuna, I want to thank you, too, for your testimony on the impact of social media on our children. My bill, the DETOUR Act, seeks to address the impact of social media by regulating a phenomenon known as dark patterns, which are design practices that manipulate people, often children, to use social media platforms compulsively.

Dr. Fortuna, why should we be concerned about these manipulative and compulsion-inducing practices when

addressing youth mental health crises?

*Dr. Fortuna. And I don't know if you want to give that to Dr. Nesi, because I think she was covering that.

*Ms. Blunt Rochester. Yes, yes. Dr. Nesi, if you would.

Thank you so much, Dr. Fortuna.

*Dr. Nesi. Absolutely. Yes, thanks for this question.

You know, I do think -- I am always hesitant to use the word "addiction'' here, as I think that, you know, addiction typically falls under the realm of a diagnosed mental illness. But we do know that there are features of social media sites that make them hard to stop using, so in some ways can lead to compulsive behaviors in some youth and adults. That is things like endless scrolls, notifications, targeted recommendations. And we do know that those things make it harder to log off of these of these platforms for people of every age, but especially teens.

*Ms. Blunt Rochester. Well, I want to thank all of you for your testimony, especially at this pivotal time in our country, and I look forward to working with you.

Thank you so much, Madam Chair, and I yield back.

*Ms. DeGette. Thank you so much. And I want to add my thanks to all of our witnesses for really illuminating this subject. I think we need to have a follow-up to this hearing.

In particular, I would like to continue our investigations into the LGBTQ community, and the disproportionate impact, and also, critically, how it impacts different racially diverse communities: the Hispanic community, the African American community, so many others, because it really -- this was a crisis before, as I said in my opening statement, but it is a crisis that has really been made more urgent by the pandemic.

I would like -- I know several members, including Dr. Burgess, would like to ask additional questions. But because of the time constraints, and the many additional members of the full committee who waived on today, we won't have time to do that now.

But I do want to remind members that, pursuant to committee rules, every member has 10 business days to submit additional questions for the record to be answered by witnesses who have appeared before the subcommittee. And I know all of the witnesses here will be eager to respond to those questions, should they receive them.

And so, with that, this important hearing is finished. I want to thank everybody, and the committee is adjourned.

[Whereupon, at 2:25 p.m., the subcommittee was adjourned.]